THE COMMONWEALTH FUND

The Commonwealth Fund 2009 ANNUAL REPORT

The Commonwealth Fund is a private foundation that promotes a high performance health care system providing better access, improved quality, and greater efficiency. The Fund's work focuses particularly on society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

Cover photo: Susie Fitzhugh

The Commonwealth Fund 2009 Annual Report

Working toward the goal of a high performance health care system for all Americans, the Fund builds on its long tradition of scientific inquiry, a commitment to social progress, partnership with others who share common concerns, and the innovative use of communications to disseminate its work. The 2009 Annual Report offers highlights of the Fund's activities in the past year.

Building a Foundation for Health Reform

THE COMMONWEALTH FUND

President's Message
2009 Annual Report

Karen Davis
President

Preface

BUILDING A FOUNDATION FOR HEALTH REFORM

Karen Davis, President
The Commonwealth Fund

The Commonwealth Fund marshaled its resources this year to produce timely and rigorous work that helped lay the groundwork for the historic Affordable Care Act, signed by President Obama in March 2010.

Anna Harkness founded The Commonwealth Fund in 1918 with the mandate to "do something for the welfare of mankind." To that end, The Commonwealth Fund and its Commission on a High Performance Health System have become leading voices for reforming the U.S. health care system—to achieve insurance coverage for all, at reasonable cost, and to ensure that services are coordinated, patient-centered, and efficiently delivered. Long before health reform became a staple of national headlines, the Fund was working to provide much-needed data on the impact of spiraling health care costs on middle-class families, businesses, and government and proposing options for "bending the cost curve." We also provided information on how the U.S. health system compares internationally—further evidence to build a compelling case for reform.

The Commission's *2008 National Scorecard on U.S. Health System Performance*—the second one it has issued—showed that the nation was losing ground in health care. In nearly every category measured, the new scorecard found that the health system performed worse than it did in 2006—largely because of worsening access to care. Similarly, Fund surveys comparing the U.S. to other industrialized nations repeatedly found that the U.S. falls far short of its peers in access, safety, and efficiency. And a highly publicized Fund-supported study released in 2008 found that the U.S. had dropped to last place, among 19 countries, on "mortality amenable to health care"—a measure of how well a health system prevents potentially avoidable deaths by ensuring that people receive timely, appropriate care for treatable conditions.

Commonwealth Fund professional staff, Commission members, and grantees also spent this critical period developing strategies to extend health insurance to all, improve care delivery, and reduce health care costs for government, employers, and individuals—approaches that ultimately helped shape the health reform legislation. As a result, we were in an ideal position to evaluate the reform proposals of the 2008 presidential candidates—and outline reform options for President Obama before he took office—drawing on such reports as *An Ambitious Agenda for the Next President* and *The 2008 Presidential Candidates' Health Reform Proposals: Choices for America*.

Working toward solutions, the Fund also launched two multiyear quality improvement initiatives—one to develop patient-centered medical homes that redesign care to ensure 24/7 access to high-quality, coordinated primary care, and one to

reduce avoidable hospital readmissions—that have already helped turn these issues into national delivery system change movements. The Safety Net Medical Home Initiative aims to develop a replicable and sustainable implementation model for medical home transformation for health centers serving low-income populations. The State Action on Avoidable Rehospitalizations (STAAR) initiative, meanwhile, is a multipronged effort administered by the Institute for Healthcare Improvement to help hospitals improve their processes for transitioning discharged patients to other care settings. We also created WhyNottheBest.org, a Web site that enables users to compare the performance of U.S. hospitals and other health care providers, and offers case studies and profiles of high-performing health care providers and best practices.

The following essays, published on the Commonwealth Fund's Web site over a one-year period, each addressed one of the five strategies for a high performance health system laid out in the Commission's report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way,* released in February 2009. Those strategies for comprehensive reform are:

- Affordable coverage for all.
- Align incentives with value and effective cost control.
- Accountable, accessible, patient-centered, and coordinated care.
- Aim high to improve quality, health outcomes, and efficiency.
- Accountable leadership and collaboration to set and achieve national goals.

The essay, "Insurance in Name Only," discussed the need to improve coverage for the 25 million Americans that Commonwealth Fund research has identified as being underinsured—meaning they have health coverage but still have medical expenses they cannot afford.

"Ensuring Accountability" reviewed an approach to realigning incentives for hospitals. Global fees, which cover a bundle of services for hospitalization and 30-day post-hospital care, can improve care, reduce complications, and generate savings. Another look at improving value, "Bending the Health Care Cost Curve: Lessons from the Past," reviewed the history of failed voluntary industry efforts to contain health care costs, and showed why policymakers need to set health reform expenditure targets.

Other essays focused on the need to organize the delivery system so that providers can better offer patient-centered, coordinated care. "Delivering Change Through Health System Organization" discussed the six attributes of an ideal health care delivery system that have been identified by the Fund's Commission and offered payment reform and other policy recommendations that would help the nation achieve it. "Can Patient-Centered Medical Homes Transform Health Care Delivery?" discussed how the medical home model can strengthen primary care. "Cooperative Health Care: The Way Forward?," a timely response to a proposal floated in the Senate at a crucial moment in the health reform debate, highlighted the challenges cooperatives would face in the health care market and the need for a national authority that would provide support and set payment rates. Accompanying that essay were case studies of the two major health care cooperatives in the U.S.: Group Health Cooperative of Puget Sound, in Seattle, and HealthPartners, in Minnesota.

Evidence of poor health system performance, drawn from Fund-supported research, that underscored the need for reform was examined in "Headed

in the Wrong Direction: The 2008 National Scorecard on U.S. Health System Performance" and "Reducing Preventable Deaths Through Improved Health System Performance."

"Health Information Technology: Key Lever in Health System Transformation" encouraged national policymakers to invest in health IT, as well as create standards and financial incentives to ensure providers will adopt and use health IT effectively.

"The Presidential Candidates' Health Reform Plans: Important Choices for the Nation," and "Health Reform in the New Era: Options for the Obama Administration" analyzed the health reform options before the country, while "Compassionate and Challenging Changes in Health Care" explained how reform would benefit patients and families, as well as all stakeholders. Together, these essays provide a picture of the major health care issues of the year and the many ways that Fund research and analysis were used to support the nation's drive toward comprehensive health reform.

For more than 90 years, The Commonwealth Fund's role in health care has been to help establish a base of scientific evidence and work toward social progress by mobilizing talented people to transform health care organizations, collaborating with organizations that share its concerns, and practicing strategic communications to reach those in a position to effect change, particularly for society's most vulnerable. We look forward to continuing our efforts to improve the health care system and the health and lives of all Americans.

December 18, 2008

The Commonwealth Fund at 90

By Karen Davis

The 90th anniversary of The Commonwealth Fund serves as an occasion to reflect on the foundation's remarkable history and its role in supporting research and innovative practices that have driven improvements in the U.S. health care system for nearly a century. Anna Harkness founded The Commonwealth Fund in 1918 with the mandate to "do something for the welfare of mankind." Her son, Edward Stephen Harkness, was the Fund's first president, and he shared his mother's commitment to building a responsive and socially concerned philanthropy. The Fund's work has always focused on the challenges vulnerable populations face in receiving high-quality, safe, compassionate, coordinated, and efficiently delivered care.

Today, the foundation—along with the Commission on a High Performance Health System, which was established by the Fund in 2005—is a leading voice for reforming the U.S. health care system to achieve coverage for all, at reasonable cost, and with services that are coordinated, patient-centered, and efficiently delivered. Since its inception, the Fund has sought to bring the international experience to bear in efforts to achieve better value for the U.S. health care dollar. The foundation combines grantmaking with intramural research and communications to help inform the health care debate and improve the performance of health care delivery.

Advancing Public Health

In its early years, public health became a major focus of the foundation's philanthropy. In the 1920s, the new field of child guidance was developed and informed by The Commonwealth Fund to provide mental health services for children. The Fund supported the first fellowships in child psychiatry and established children's community clinics. Model public health clinics established by the Fund not only set standards for public health departments across the United States, but also spurred initiatives to reduce maternal and infant mortality.

In the 1930s, the rural hospital program helped to improve services in remote areas, paving the way for the passage of the Hospital Survey and Construction (Hill-Burton) Act of 1946 that brought federal funds to build and improve community hospitals. A 1933 Commonwealth Fund publication, *A Standard Classified Nomenclature of Disease,* brought a common terminology to medicine, allowing hospitals to more easily compile statistics and exchange information about the prevention and treatment of disease.

The Fund also advanced medical research in significant ways. Dr. George Papanicolaou's Fund-supported research in the 1940s led to the highly effective technique for detecting cervical cancer that became known as the Pap test. In the next decade, Fund support for research that refined cardiac catheterization as a diagnostic treatment for pulmonary heart disease resulted in the 1956 Nobel Prize for the physicians.

The Fund has similarly supported medical education over the years. The foundation was an early advocate of minority medical education through scholarships and grants, as well as funding for minority medical schools. In the 1960s, the

Fund supported the first training programs for physician assistants, nurse practitioners, and nurse midwives—establishing health professions that play a critical role in health care today.

In the 1970s, the Fund fostered the hospice care movement, pioneering sensitive care and support for the dying and their families through its support of the first modern hospice program, Hospice, Inc., in Connecticut. In the 1980s, it supported advanced nurse training, including business administration, to prepare nurses for positions of leadership responsibility.

Moving Toward a High Performance Health System

More recently, The Commonwealth Fund has developed pragmatic strategies for expanding health insurance to all. These approaches are designed to build on parts of our current system that work well—Medicare, the State Children's Health Insurance Program, employer-based coverage, and the more recently established Massachusetts health insurance connector, which enables residents to purchase affordable private or public coverage. Ideas proposed in Fund staff-authored *Health Affairs* articles, such as "Creating Consensus on Coverage Choices" and "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," have been embraced and advanced by state and national policy leaders, including president-elect Barack Obama. Such publications spell out specific changes needed to improve health system performance and bring about universal coverage.

Through its surveys and analyses, the foundation and its Program on the Future of Health Insurance have led the field in defining gaps in insurance coverage and the concept of underinsurance. The Fund has also emerged as an evidence-based voice for preserving the role of employer-sponsored health insurance.

The Fund's Program on Medicare's Future provided original analysis and research that eventually helped inform the Medicare Part D prescription drug benefit. More recent Fund-supported Medicare research has looked at ways to protect access to care for vulnerable beneficiaries and focused on the overpayment of Medicare Advantage plans and their record of performance.

The Commonwealth Fund's Program on Health Care Quality Improvement and Efficiency has helped to promote the development and adoption of health care quality and efficiency measures and enhance the capacity of health care organizations to provide better care more efficiently. The program has been a leading force in payment reform, supporting the development, testing, and evaluation of new payment approaches that align financial incentives of hospitals and physicians with quality and efficiency.

The Picker/Commonwealth Patient-Centered Care Program of the 1990s succeeded in making the patient experience a focus of medical care through the development of hospital patient surveys. Today, the Picker/Commonwealth Fund Program on Quality of Care for Frail Elders aims to transform the nation's nursing homes and other long-term care facilities into resident-centered organizations that are good places to live and work and are capable of providing the highest-quality care.

The Patient-Centered Primary Care Program was launched in 2005 to encourage the redesign of primary care practices and health care systems around the needs of the patient. It is now supporting a number of evaluations of the medical home model.

The Fund's Child Development and Preventive Care program has successfully supported states in improving the delivery of early child development services and building the capacity of Medicaid programs to deliver care that supports healthy mental development. As a result of the Fund's work over the last decade, screening and referrals for developmental problems are now standard features of modern pediatric practice.

The Fund's new state scorecard on health system performance and the State Quality Leadership Institute have helped trigger state policy officials' interest in policy actions to improve quality and enhance value. Fund-sponsored evaluations of health reform in Massachusetts and Maine are now informing the national debate.

Commonwealth Fund-supported work has improved data collection and reporting on health disparities. It has also helped define and develop standards for cultural

competence. Today, the Program on Health Care Disparities aims to improve the performance of minority serving safety-net hospitals and ambulatory care providers. In addition, the Commonwealth/Harvard Minority Health Policy Fellowships, with 80 graduates, is producing a cadre of future leaders committed to addressing disparities in health care.

On the international level, the Fund's comparative data on health system performance has stimulated high-level thinking about methods to improve policies and practices in the U.S. and other industrialized countries. And the Harkness Fellowship in Health Policy has more than 100 international alumni who continue to serve as forces for health system change in their home countries.

Finally, through its Commission on a High Performance Health System, the Fund is supporting strategies for making the U.S. health system the best it can be, learning from best practices and outstanding performance within the U.S. and around the world. Its national and state scorecards are spurring improvements in health care providers and policy.

In this time of crisis and change, The Commonwealth Fund plans to continue its great tradition of service by supporting research and finding solutions that will move the U.S. ever closer to a high performance health system.

June 24, 2008

Insurance in Name Only

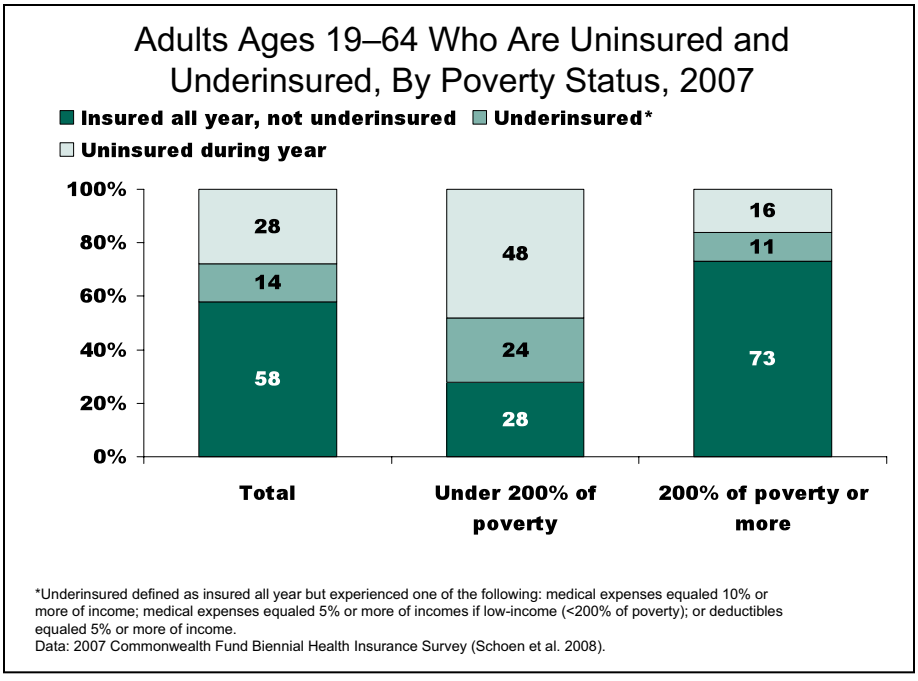
By Karen Davis

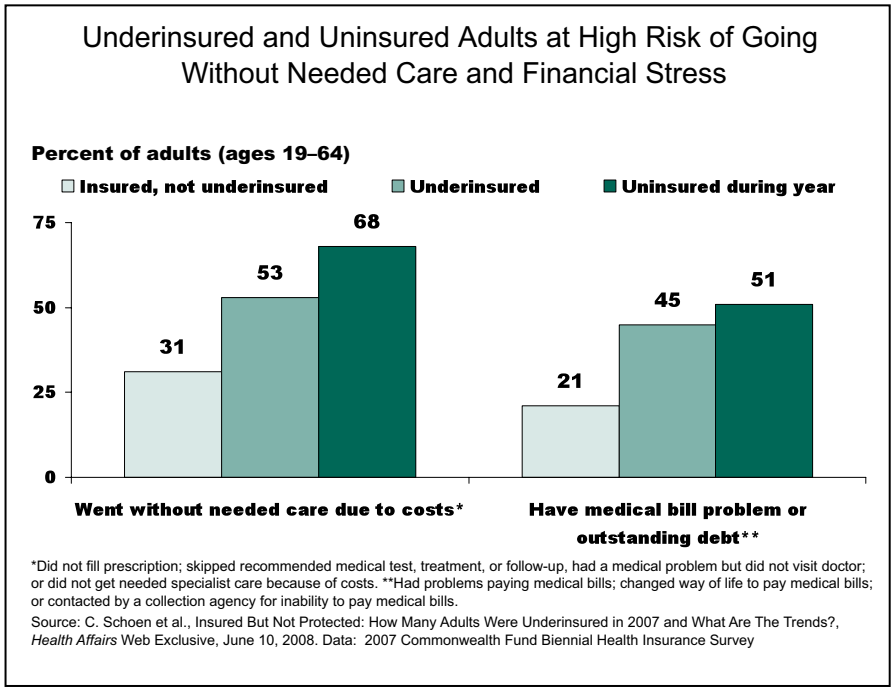
The purposes of health insurance are to ensure financial access to needed care and protect against financial hardship from medical bills. Unfortunately, for many of those with health insurance, neither purpose is fulfilled. A Commonwealth Fund study published earlier this month in *Health Affairs* showed that 25 million Americans are underinsured, meaning they have health coverage but still have medical expenses they cannot afford. The number of underinsured has risen by 60 percent since 2003. When added to those who are uninsured at some point during the year, 42 percent of all adults—and 72 percent of those with incomes below twice the poverty level—are inadequately or unstably insured.

Unaffordable Care

According to the study, people who don't have adequate coverage have many of the same experiences as the uninsured. More than half of the underinsured (53%) and two-thirds of the uninsured (68%) went without needed care—including not seeing a doctor when sick, not filling prescriptions, and not following up on recommended tests or treatment. Only 31 percent of insured adults went without such care. Forty-five percent of the underinsured had a medical bill problem or medical debt, compared with 51 percent of the uninsured and 21 percent of the insured.

The problem has quickly worked its way up the income ladder. Since 2003, rates of underinsurance have tripled among middle-income Americans, or families making more than $40,000 per year.



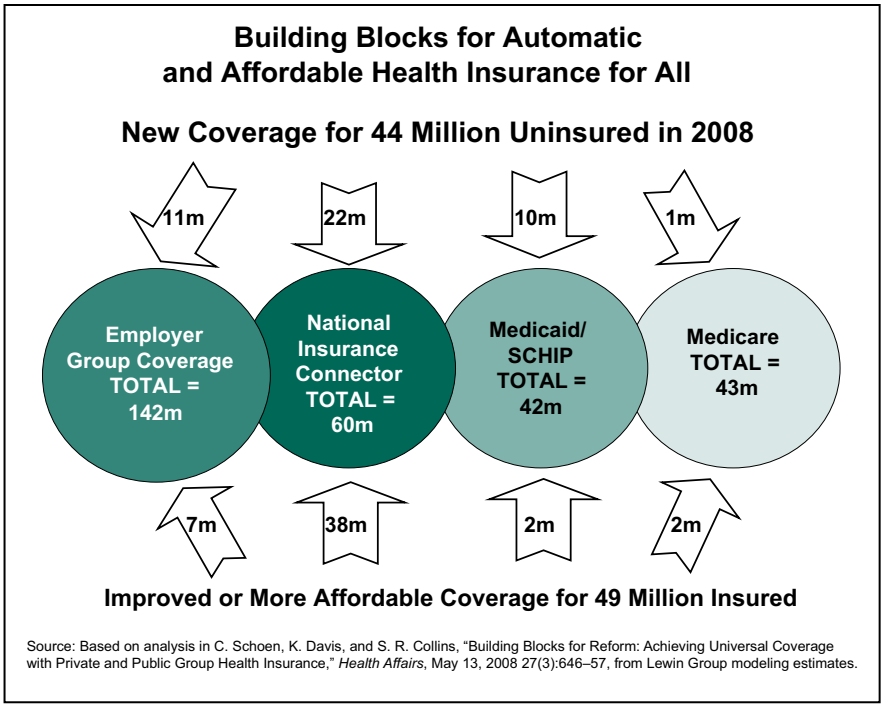


The study authors, the Commonwealth Fund's Cathy Schoen, Sara R. Collins, Jennifer L. Kriss, and Michelle M. Doty, conclude that a variety of factors related to insurance design are responsible for this growth. Health insurance premiums have risen at a much faster rate than wages. And because of rising costs, employers are often selecting plans for their employees with benefit limits, such as a set number of physician visits or restrictions on the total amount a plan will pay for medical care. Plans available through the individual insurance market are even more likely to have such restrictions. The underinsured also were far more likely to report having high deductibles: one-quarter had annual per-person deductibles of $1,000 or more.

Well-Designed, Universal Coverage

The growing number of people with inadequate health insurance underscores the need for universal coverage that has comprehensive benefits. Such a system is feasible as spelled out in a "Building Blocks" framework described in another recent *Health Affairs* article, which I coauthored with Fund colleagues Cathy Schoen and Sara Collins. This framework sets forth a shared private–public solution that would benefit both the uninsured and the underinsured.

Under the *Building Blocks* framework, small businesses, the uninsured, and the self-employed could find coverage through a new national insurance connector that would offer a choice between a Medicare-like option with enhanced benefits, called Medicare Extra, and private plans. The premiums for Medicare Extra would be community-rated for everyone under age 60, estimated at $259 per month for single premiums and $702 per month for families in 2008. These premiums would be 30 percent lower than those generally charged for employer-sponsored plans because of Medicare's lower administrative costs and provider payment rates.



Other components of *Building Blocks* include: requiring that all individuals obtain health insurance, with automatic enrollment through the personal income tax system; a pay-or-play requirement for employers, who must cover their workers or contribute 7 percent of earnings up to $1.25 per hour; and expansion of Medicaid and the State Children's Health Insurance Program (SCHIP) to cover all low-income adults and children below 150 percent of the federal poverty level. The plan also involves scaled tax credits to offset premiums that exceed 5 or 10 percent of one's income as well as several Medicare reforms, such as the elimination of the two-year waiting period for people with disabilities and the option for adults over age 60 to buy in to Medicare.

This plan would achieve near-universal coverage, with 99 percent of the population participating. Forty-four million uninsured people would find affordable coverage—from employers, the national insurance connector, Medicaid/SCHIP, or Medicare. By building on the experience of Medicare and offering a Medicare Extra option to individuals and small firms, our plan would benefit the underinsured as well as those who are now paying much higher premiums. An estimated 49 million people would change coverage—finding lower premiums or better benefits through the insurance connector or public programs. By offering more choices, including the option of enrolling in public programs, all Americans would have the financial security that insurance is intended to provide.

We cannot accept a health care system in which 42 percent of Americans under age 65 are uninsured or underinsured. We must pursue a workable solution that mixes private and public coverage well before the majority of Americans find themselves with no coverage or coverage that has been chipped away until it no longer serves its purpose.

April 29, 2009

Ensuring Accountability: How a Global Fee Could Improve Hospital Care and Generate Savings

By Karen Davis and Kristof Stremikis

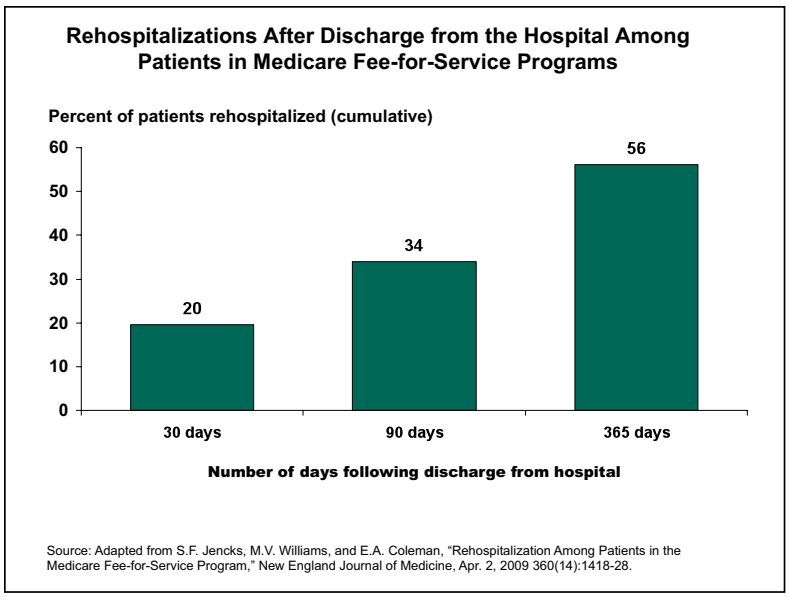
As U.S. federal policymakers embark on the much-needed expansion of our system of health insurance coverage, it is important to also examine how we organize and deliver health services. Looking closely at delivery will ensure both the best possible health outcomes for Americans and the most value for what we spend on health care.

Today, U.S. health care delivery is disorganized and rife with examples of missed opportunities and waste. The high rate at which patients are readmitted to the hospital within 30 days of discharge is particularly alarming. Working within a payment system that doesn't encourage quality or efficiency, hospitals and post-acute providers often fail to properly coordinate services throughout the course of a patient's treatment and follow-up. This practice leads to hospital readmissions that are not only wasteful and costly but also potentially dangerous. To break this cycle, the U.S. needs to realign health care providers' financial incentives. Offering a "global fee" that covers a bundle of "best-practice" services for hospitalization and 30-day post-hospital care has great potential to improve care, reduce complications, and generate savings to finance health reform.

Evidence of Avoidable Complications and Costly Care

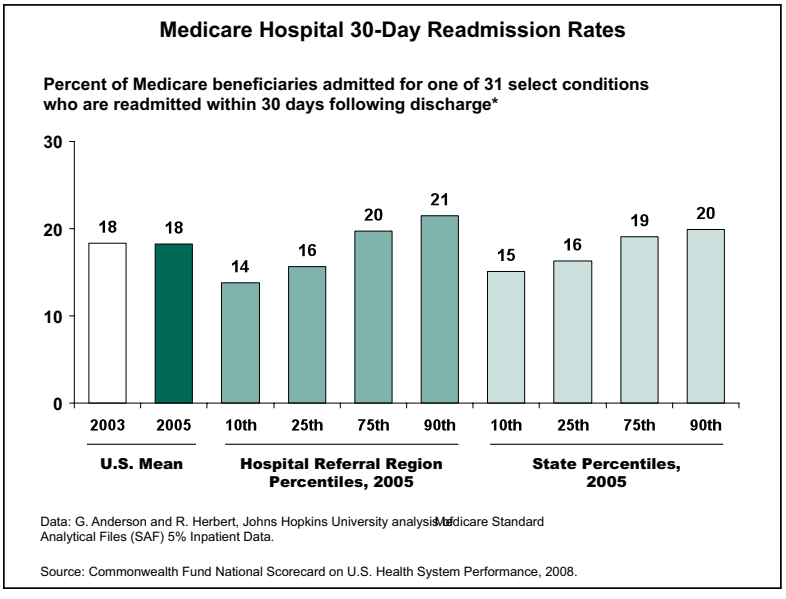
Hospital readmissions are a key indicator of overall health care quality. Commonwealth Fund-supported work has repeatedly demonstrated the troubling prevalence and costs of hospital readmissions in Medicare, as well as the wide variation in rates. A recent examination of fee-for-service claims data by Stephen Jencks, M.D., M.P.H., and colleagues found that one of five people with Medicare who was discharged from a hospital in 2003 and 2004 was readmitted within 30 days (Exhibit 1). While there is no doubt that some of these readmissions were unavoidable, it is likely that many could have been prevented with appropriate discharge planning, follow-up treatment, and post-acute care. In Dr. Jencks' study, half of the people who were hospitalized for reasons other than surgery were re-hospitalized without having seen an outpatient doctor for follow-up.

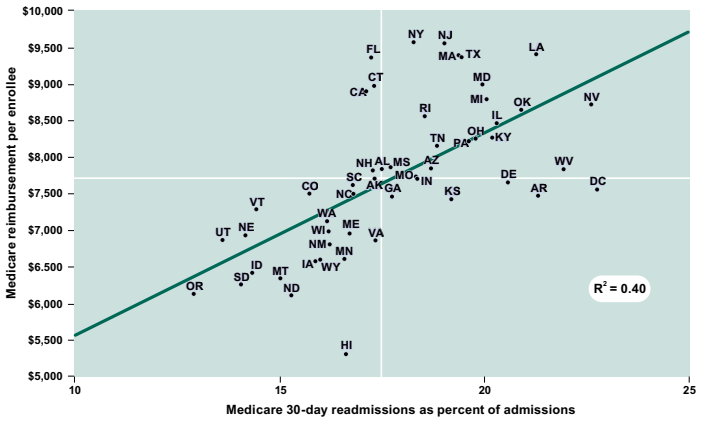
In its most recent national scorecard, the Commonwealth Fund Commission on a High Performance Health System found that the average 30-day hospital readmission rate for Medicare beneficiaries remained constant between 2003 and 2005, suggesting that we have not made needed improvements in post-acute care coordination and efficiency.



Fund studies have also uncovered wide variation across hospitals and geographic areas. The national scorecard revealed that the percentage of Medicare beneficiaries readmitted within 30 days (for 31 selected conditions) ranged from 14 percent for the 10 percent of hospital referral regions with the lowest readmission rates to 21 percent for the 10 percent of regions with the highest rates (Exhibit 2).

Finally, hospital readmissions are expensive and drive significant variation in Medicare spending, ultimately contributing to unsustainable growth in national health care expenditures. Dr. Jencks and colleagues estimated that the cost of unplanned hospital readmissions accounted for $17.4 billion of the $102.6 billion in total hospital payments made by Medicare in 2004. Analysis by Commonwealth Fund board member and Medicare Payment Advisory Commission (MedPAC) Chairman Glenn Hackbarth, J.D., has shown that a significant proportion of variation in Medicare spending can be traced to variability in readmissions and post-acute care. For example, spending on readmissions can vary from hospital to hospital by 54 percent and by as much as 71 percent for post-acute care for coronary-artery bypass grafting with cardiac catheterization, a common procedure. The Commonwealth Fund Commission documented the high correlation between hospital readmissions and total Medicare spending per beneficiary in its most recent state scorecard (Exhibit 3).





Data: Medicare readmissions—2006–07 Medicare 5% SAF Data; Medicare reimbursement—2006 Dartmouth Atlas of Health Care.
Source: Commonwealth Fund State Scorecard on U.S. Health System Performance, 2009.

Realigning Incentives to Reward Efficiency and Increase Value

Recent proposals in President Obama's budget blueprint, the Commonwealth Fund Commission's *"Path"* report, and Senator Max Baucus' white paper on health reform would realign financial incentives to encourage greater coordination by bundling hospital payments for inpatient care, as well as post-acute health services for a predetermined number of days following hospitalization. Under the President's proposal, bundled payments are combined with reduced reimbursements for hospitals with high rates of 30-day readmission. The Administration expects this combination of incentives and penalties to save $8 billion through reduced readmissions and $18 billion through increased efficiency in post-acute care, totaling $26 billion in savings over the 10-year, 2010-2019 period.

The Commonwealth Fund Commission also recommends applying new payment methods to acute-care episodes to encourage hospitals and other providers to collaborate in developing the capacity to provide high-quality and efficient care for their patients. Offering a bundled acute-care payment (a global fee covering hospitalization and a specified set of services for 30 days following discharge) would give hospitals and other providers an opportunity to share the savings from their efforts to reduce complications of treatment and lower numbers of readmissions and would allow them more flexibility in allocating their resources. Over time, spending would slow as efficiency savings were shared between Medicare and providers. The Lewin Group estimated that within the context of comprehensive insurance expansion and other system-wide reforms, the bundled payment approach proposed by the Commission would reduce national health expenditures by $301 billion and save the federal government $211 billion over the 11-year, 2010–2020 period.

Senator Baucus' "Call to Action" on health reform includes a proposal for reducing hospital readmissions that utilizes global-care case rates and a phased strategy similar to the bundled payment approach outlined in the Medicare Payment Advisory Commission's June 2008 Report to Congress. Both the Senator and MedPAC call for initially disclosing readmission rates and resource use only to hospitals and physicians, allowing providers to understand spending levels and improve performance before releasing such data to the public. The Senator further recommends reducing reimbursement to hospitals with high rates of readmission for a small number of conditions before expanding the program to include a full range of services. Finally, the proposal includes support for additional testing and implementation of bundled payment policies among participants in the Centers for Medicare and Medicaid Services Acute Care Episode demonstration.

Promising Interventions Already Underway

Evidence suggests that health care providers can follow a number of proven strategies to reduce hospital readmissions and increase efficiency. With support from the Commonwealth Fund, the Institute for Healthcare Improvement (IHI) recently completed a survey of the published evidence on effective interventions to reduce rehospitalizations and a compendium of 15 promising initiatives already underway. In their review of the literature, IHI identifies four common themes among successful interventions: 1) enhanced care and support during transitions; 2) improved patient education and self-management support; 3) multidisciplinary team management; and 4) patient-centered care planning at the end of life.

The IHI compendium includes four interventions with very strong clinical trial or program evaluation evidence, seven with very good evidence, and four that have potential but require additional data. For the interventions bolstered by very strong evidence, patient education, post-discharge care planning, and provider coordination were among the factors that contributed to reduced rates of rehospitalization. Initiating reminder calls for preventive care, empowering nurse practitioners to work as care managers, and utilizing multidisciplinary clinical teams were all effective components of programs with very good evidence of reducing hospital readmissions.

Through its health plan, Geisinger Health System, on whose board of directors I serve, has pioneered testing payment of a global fee for a basket of best-practice services for various surgical procedures and obstetrical care. Beginning in 2006, Geisinger used American Heart Association and American College of Cardiology guidelines for coronary artery bypass graft surgery (CABG) to develop and implement 40 verifiable best-practice steps in performing this procedure. It increased the proportion of patients receiving all 40 best-practice steps from 59 percent to 86 percent within three months, and then reached and maintained 100 percent performance, with few exceptions. Its Geisinger Health Plan offered a global fee "with a warranty" covering pre-operative, operative, post-operative, and rehabilitative services for 90 days post-discharge. Complications declined by 21 percent, readmissions declined by 44 percent, and the average length of stay declined by half a day. In short, this change in delivery and payment was a win-win: it improved patient outcomes and reduced cost. Geisinger has subsequently extended this strategy to other areas, including hip replacement, cataract surgery, obesity surgery, and prenatal care and delivery of newborns.

A Win-Win

Offering a global fee for a package of best-practice services covering hospitalization and care for 30 days following discharge will reduce our overall hospital readmission rate, as well as the hospital and geographic variation in readmissions and post-acute-care spending. By realigning financial incentives to reward quality and efficiency, policymakers can eliminate the barriers to coordination among hospitals and post-acute providers built by the current fee-for-service payment system. Instead, providers will be encouraged to collaborate and rewarded for providing a continuum of care throughout the entire course of a patient's treatment and follow-up.

This is indeed a win-win strategy. The current health reform debate calls for bold hospital payment reform to enable hospitals, physicians, and post-acute care providers to achieve the best possible outcomes for patients, hold providers accountable for improving care and realizing the potential savings, and reward providers for doing so. Medicare should quickly replace its current hospital payment system with a global fee including post-discharge care.

New health insurance plans developed as part of health reform to cover the uninsured should similarly be encouraged to adopt innovative payment methods. Hospitals should be permitted to keep a share of the savings as a reward for better care, but the net savings to the federal government should be dedicated to covering the uninsured. Such savings could increase the $634 billion health reform reserve fund already proposed by the President over the 10-year period from 2010–2019 by more than $100 billion. These resources will help ensure that all Americans have affordable health insurance coverage. Lower premiums would also ease financial burdens on employers by $75 billion over 2010–2020. And premium savings for workers will provide financial relief in these difficult economic times. It is time to transform our current system of payment and delivery of health care into a system that not only provides better quality care but also bends the health-care cost curve.

May 26, 2009

Bending the Health Care Cost Curve: Lessons from the Past

By Karen Davis

In a May 11 letter to President Obama, the leaders of six health care organizations—the Advanced Medical Technology Association, the American Medical Association, America's Health Insurance Plans, Pharmaceutical Research and Manufacturers of America, American Hospital Association, and Service Employees International Union—expressed their support for health reform, writing: "We will do our part to achieve your Administration's goal of decreasing by 1.5 percentage points the annual health care spending growth rate—saving $2 trillion or more."

The organizations went on to say that they are developing consensus proposals on administrative simplification, standardization, and transparency; reducing overuse and underuse; encouraging coordinated care and adherence to evidence-based best practices and therapies; improvements in care delivery models, health information technology, workforce deployment and development; and regulatory reforms. The organizations also indicated that they support health promotion and disease prevention, including obesity prevention.

In response, a White House Fact Sheet stated that health care industry leaders "are proposing to take aggressive steps to cut health care costs that, if done in the context of comprehensive health reform, will reduce the annual health care spending growth rate by 1.5 percentage points for the next 10 years." By the end of the week, the industry coalition clarified that they did not commit to a specific and immediate year-by-year target, though their statement did not retract their promise of $2 trillion in savings over 10 years.

This back-and-forth between the government and industry signals the difficulty of developing, enacting, and implementing effective measures to bend the health care cost curve. What should be clear, however, is that a strictly voluntary effort to slow the growth in costs is unlikely to be successful, and that health reform will need to incorporate legislative provisions and enforcement mechanisms to ensure that spending targets are met. The Medicare Trustees' recent report that the Hospital Insurance Trust Fund will be exhausted in 2017 underscores the need to take effective action.

As we prepare health reform legislation, the history of failed voluntary health care efforts in other periods of crisis is instructive. President Nixon imposed wage and price controls on the nation's economy in the wake of inflation triggered by the Vietnam War. Congressional legislative efforts to retain these controls in the health sector after the Executive Order expired were defeated when industry leaders pledged to control costs voluntarily. Similarly, President Carter's proposed hospital cost-containment legislation was defeated with a promise from industry leaders that a "Voluntary Effort" would be sufficient to stem inflationary increases in hospital spending. An in-depth look at those prior efforts yields important lessons for the challenges ahead.

Voluntary Efforts: A Dismal History

From 1968 through 1970, when the overall inflation in the economy was 5.2 percent, Medicare hospital expenditures increased at an annualized rate of 18.1 percent, making health care costs an issue of intense concern. In 1971, President Nixon put a wage and price freeze on the entire economy, including the health sector, by Executive Order. Later that year, the freeze was replaced by an initiative with specific inflation targets for each sector of the economy. By the following year, a ceiling of 5.5 percent on health care wage increases, 2.5 percent for non-labor costs, and 1.7 percent for new technology and services was imposed.

When the Executive Order expired in 1974, Congress sought to continue the health care cost controls legislatively. The hospital industry strenuously opposed legislation and promised to control costs voluntarily. However, once the Economic Stabilization Program controls on the health sector were lifted, health expenditures increased rapidly.

When President Carter assumed office in January 1977, hospital expenses were increasing annually 8.7 percent faster than the overall inflation rate, posing a serious obstacle to his plans to balance the federal budget and expand health insurance coverage to the entire population. In February, Carter announced his intention to submit a major legislative proposal constraining the rate of increase in hospital costs, and as a new appointee at the Department of Health, Education, and Welfare, I was charged with developing the proposal. In April 1977, we submitted to Congress a plan to limit the rate of increase in hospital revenues for all patients to 3 percentage points over the overall inflation rate.

The major argument launched by the industry was that they could voluntarily contain costs without federal legislation. After extensive debate and Committee action, a bill passed the Senate in late 1978 that provided for a period of voluntary restraints on hospital cost growth, and a trigger initiating mandatory controls if the voluntary effort failed, but the session ended without action on the House floor. In 1979 at the behest of congressional leaders, the Carter administration introduced a new hospital cost-containment bill that contained a voluntary trigger, specifying that mandatory limits would only be imposed if national, state, and individual hospital voluntary limits were not met, with limits set comparable to industry voluntary goals. The bill passed three major committees, but was defeated on the House floor in November 1979.

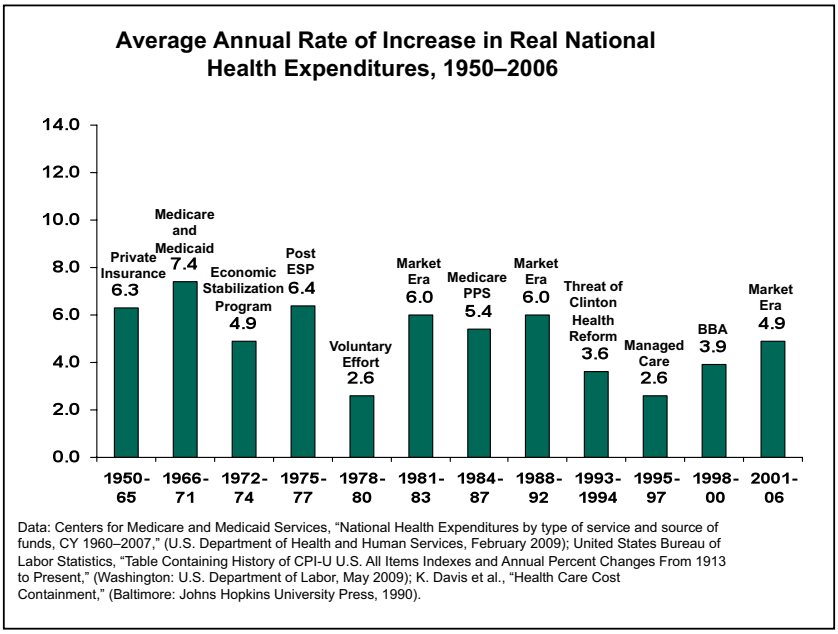
It was the launch of a formal Voluntary Effort created by a coalition of health care provider organizations (most notably the American Hospital Association, the Federation of American Hospitals, the American Medical Association, and Blue Cross/Blue Shield) that nailed the lid on the legislative coffin. The coalition set a 1978 goal of reducing the rate of increase by 2 percentage points below the 1977 rate of increase; that goal of 13.6 percent increase in 1978 was met. All subsequent goals, as well as goals related to holding down increases in the number of beds and employees, as well as increases in capital investment were substantially exceeded, leading to the end of the effort in 1981 and congressional hearings at which I testified that led to a new system of Medicare hospital payment.

The failure of the Voluntary Effort set the stage for enactment of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) that established a limit on the rate of increase in Medicare hospital payment rates based on a hospital market basket price index, plus 1 percent for new technology and services. The TEFRA legislation in turn paved the way for enactment of the Medicare hospital prospective payment system based on Diagnosis Related Groups (DRGs). Beginning in October 1, 1983, hospitals were paid a prospectively determined payment rate for each hospital patient, rather than its own costs. Payment rates were to

The Voluntary Effort: A Litany of Broken Promises

Annual Percent Increase in Hospital Expenses			
	Goal	Actual Performance	Promise
1978	13.6%	12.8%	Kept
1979	11.6	13.4	Broken
1980	11.9	16.8	Broken
1981	Below 16.8%	18.9*	Likely Broken

* January-August 1981
Source: K. Davis, "Recent Trends in Hospital Costs: Failure of the Voluntary Effort, testimony before House Energy and Commerce Committee, December 15, 1981.

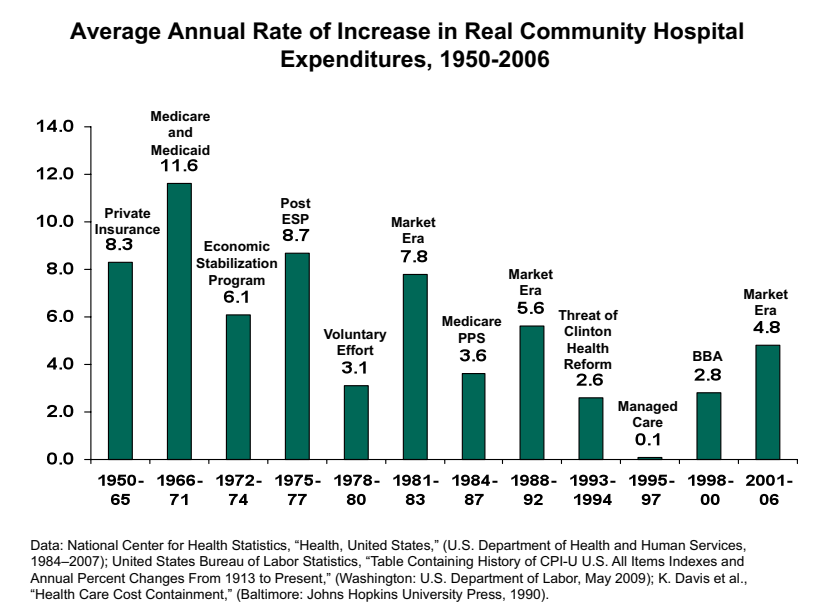


Data: Centers for Medicare and Medicaid Services, "National Health Expenditures by type of service and source of funds, CY 1960–2007," (U.S. Department of Health and Human Services, February 2009); United States Bureau of Labor Statistics, "Table Containing History of CPI-U U.S. All Items Indexes and Annual Percent Changes From 1913 to Present," (Washington: U.S. Department of Labor, May 2009); K. Davis et al., "Health Care Cost Containment," (Baltimore: Johns Hopkins University Press, 1990).

increase each year at the rate of increase in the hospital market basket price index plus 1 percentage point. The legislation created the Prospective Payment Assessment Commission (now called the Medicare Payment Advisory Commission) to oversee the system and make recommendations to Congress. During periods when Congress has acted to limit increases in hospital payment rates, Medicare spending has slowed relative to private sector spending.

Lessons from Past Efforts to Control Costs

This history is pertinent to today's health reform consideration. Industry leaders' response to federal consideration of mandatory controls has consistently been to promise voluntary efforts. Yet without an enforcement mechanism those promises have quickly evaporated as each individual provider independently pursues its own interests. But controls—whether crude controls like the Nixon wage and price controls and the TEFRA limits on Medicare hospital payment increases or more sophisticated approaches like



Data: National Center for Health Statistics, "Health, United States," (U.S. Department of Health and Human Services, 1984–2007); United States Bureau of Labor Statistics, "Table Containing History of CPI-U U.S. All Items Indexes and Annual Percent Changes From 1913 to Present," (Washington: U.S. Department of Labor, May 2009); K. Davis et al., "Health Care Cost Containment," (Baltimore: Johns Hopkins University Press, 1990).

the Medicare DRG prospective payment legislation—have worked to slow increases.

To ensure the promised savings are realized, policymakers should consider incorporating into health reform expenditure targets that hold increases to 1.5 percentage points below baseline projections. As several analysts have pointed out, reducing the annual growth rate in national health expenditures by 1.5 percent means that the entire health care industry can still expect sustained revenue increases over the coming decade. Moreover, if cost reduction targets are incorporated into larger payment reform efforts that reward quality and value, ample opportunities for revenue growth will exist for efficient and innovative insurers and providers.

A commitment from business and industry to limit the unsustainable increases in health care is important as we work together to build a high-performance health system that works for all Americans. The President and Congress now need to follow up on this pledge with legislation that ensures the promise is kept.

August 14, 2008

Delivering Change Through Health System Organization

By Karen Davis

"Change" is on the minds of many Americans during this election cycle, and it is relevant to any discussion of the U.S. health care system as well. Our health care system must change: while we spend more than twice as much on health care as any other nation—over $7,000 per capita in 2006—we do not, on the whole, get good value for our health care dollar. The U.S. falls short on many performance measures when compared with other countries, and there is tremendous unexplained variation in health care quality and costs across states and regions.

Americans are feeling firsthand the effects of this expensive, sometimes inadequate care. A survey of the public published this month conducted by Harris Interactive on behalf of the Commonwealth Fund's Commission on a High Performance Health System found that eight of 10 respondents agree that the health system needs either fundamental change or complete rebuilding. Nine of 10 adults say it is very important for the 2008 presidential candidates to seek reforms that address health care quality, access, and costs.

Americans' health care experiences offer further evidence of the need for change. Health care delivery in the United States is fraught with fragmentation at the national, state, community, and practice levels. There is no single national entity or set of policies guiding the overall organization of the health care system. Doctors and hospitals practicing in the same community and caring for the same patients are not "connected" to each other, and there is a critical shortage of primary care providers. And our current disjointed financing model—a mix of private insurers and public programs, each with its own set of rules and payment methods—further fragments the health care delivery system, contributing to waste and high administrative costs. Greater organization is instrumental to ensure timely access to care, care coordination, and smooth flow of information among doctors and patients.

So what do I mean by an organized health care system? I mean a system that—at every point on the care continuum—makes it easy for patients and families to obtain the comprehensive, coordinated care they need. Second, but just as important, I mean a system that does everything it can to support physicians and other providers so they can deliver that excellent care.

As outlined in the Commission report published with the public views survey, *Organizing the U.S. Health Care Delivery System for High Performance*, an ideal health care delivery system that is truly patient-centered would have six key attributes:

1. Patients' clinically relevant information is available to all providers at the point-of-care and to patients through electronic health record systems;

2. Patient care is coordinated among multiple providers and care transitions across settings are actively managed;

3. Providers (including nurses and the rest of the care team) both within and across settings have accountability to each other, review each other's work, and work together to reliably deliver high-quality, high-value, care;

4. Patients have easy access to appropriate care and information, including off-hours. There are multiple points of entry to the system, and the providers are culturally competent and responsive to the needs of the patient;

5. There is clear accountability for the total care of the patient; and

6. The system is continuously innovating and learning in order to improve the quality, value, and patient experience of health care delivery.

Any policies put in place to achieve these attributes should work for different kinds of organizations, from small practices and unrelated hospitals to fully integrated delivery systems. The authors of the report identify a combination of scalable policies that would be critical to achieving greater organization across a continuum of organizations. For example, payment reform—including the development of bundled payment systems that reward coordinated, high-value care rather than individual services—could range from blended fee-for-service and per-patient fees for primary care practices that act as medical homes to global fees for an acute hospitalization and follow-up care over 30 days. Such payment systems, along with paying providers for achieving certain levels of quality, would help coordinate the delivery of care.

Beyond payment reform, we need a center to evaluate the comparative effectiveness of drugs, devices, procedures, and we need to design health benefits around those recommendations. We also need to introduce an insurance connector to offer affordable choices to small employers and individuals, including the option of purchasing coverage through a public plan using these new payment and benefit design principles. Most of all, we need national leadership among all stakeholders, including government, providers, employers, and consumers—real leadership that recognizes the value of public-private collaboration.

In the end, changes of the kind I've described will work only if physicians and other health care professionals see in them the opportunity to provide all of their patients with the best care possible. The reforms must support providers in improving the quality of care and realign financial incentives to reward high-quality, efficient care. This would include rewards for delivering better care and better outcomes, rather than simply providing more services, which is what the current, predominantly fee-for-service system rewards.

W. Edwards Deming, one of the fathers of quality improvement, once said, "It is not necessary to change. Survival is not mandatory." Yet, most of us have a fairly strong survival instinct, and most physicians and other health care providers are driven by a continual search for more effective ways to keep people healthy and care for the sick.

What is needed in the national debate is consensus that the status quo is no longer acceptable. Working together we can change course—and move the U.S. health system on a path to high performance.

March 27, 2009

Can Patient-Centered Medical Homes Transform Health Care Delivery?

By Melinda K. Abrams, Karen Davis, and Christine Haran

Now that President Obama has set aside $634 billion in his budget for health reform, national policymakers need not only to outline overarching reform strategies but also consider how the system will work from the ground up. While much focus has been on how affordable coverage will be achieved, an equally important aspect of reform will be an overhaul in the delivery of care. This new delivery system must be built on a solid foundation of primary care.

Enter the medical home, a building block needed to ensure accessible, patient-centered, and coordinated primary care. The medical home is an approach to primary care organized around the relationship between the patient and the personal clinician. First championed by the American Academy of Pediatrics, the medical home is broadly defined as primary care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."

Why the U.S. Needs Medical Homes

In 2007, four primary care specialty societies—representing more than 300,000 internists, family physicians, pediatricians, and osteopaths—agreed on the Joint Principles of the Patient-Centered Medical Home:

- personal physician;
- whole-person orientation;
- safe and high-quality care (e.g., evidence-based medicine, appropriate use of health information technology);
- enhanced access to care; and
- payment that recognized the added value provided to patients who have a patient-centered medical home.

Today, few Americans say they have a source of care with these features. In fact, the Fund's *2008 National Scorecard on U.S. Health System Performance* found that only 65 percent of adults under age 65 reported that they have an accessible primary care provider; there were wide variations by race, income, and insurance status. Only half of the overall group said they had received all recommended screening and preventive care. Among adults who were uninsured all year, just 30 percent had received the appropriate preventive care. A 2008 Fund survey showed almost half of U.S. adults report a lack of care coordination, such as a specialist not receiving basic information from their primary care provider and vice versa, or never being called about test results. The Fund's 2008 *Scorecard* shows that only a little more than half of all Americans report open and clear communication with their primary care clinician. When there is good communication, and care is delivered in a timely and coordinated manner, patients are more likely to adhere to treatment plans, fully participate in decisions, and receive better care overall.

Creating medical homes throughout the country will clearly require a significant restructuring of our existing health care delivery "system." Whereas most doctors' offices and hospitals are currently isolated from each other—electronically and otherwise—providing patients with around-the-clock access to coordinated care will require that providers are linked and working together. For example, small physicians' offices could pool with other offices to provide regional urgent care centers that would be open from 5 p.m. to 9 a.m. Individual practices also will need support to redesign their practices or clinics as medical homes. A recent study of primary care practices in Massachusetts showed that many practices do not currently have the information systems, personnel, or continuous quality improvement initiatives in place to function as medical homes.

While the medical home is not a "magic bullet" that will provide an immediate return on the investment, studies have demonstrated tangible benefits, including improved quality, lower costs, and fewer disparities in care.

Medical homes are associated with better preventive care and improved chronic disease management (chronic diseases are a major source of high health care costs). Forty-two percent of people with a medical home have regular blood pressure checks, for example, compared with 20 percent without a regular source of care or medical home, according to the Fund's 2006 Health Care Quality Survey. Furthermore, patients with medical homes are more likely to report better access to care, better coordination of care, improved communication with their primary care provider, and fewer medical errors. The quality survey also showed that medical homes do not just improve, but actually eliminate, disparities in getting needed medical care.

Medical homes also produce efficiencies. U.S. adults with medical homes were less likely to have medical reports unavailable during a visit or to have to undergo duplicative tests, according to the Fund's latest international survey. A Fund case study of a system offering medical homes, the MeritCare System in North Dakota, demonstrated that pilot programs addressing the management of chronic diseases such as diabetes and asthma resulted in substantive costs savings.

Ongoing Fund-supported demonstration and evaluation projects, including a new initiative to transform safety-net clinics into patient-centered medical homes, will generate more information about the value of medical homes and how to turn practices into medical homes. Additionally, several ongoing rigorous evaluations of medical home demonstrations will help determine if they improve quality and slow the rate of health care expenditures. The evaluations vary considerably, from a randomized, controlled trial with one commercial payer to multistate, multipayer efforts that involve national health plans collaborating with the Medicaid program to support new reimbursement and delivery models for medical homes. All of the studies will examine the impact of the medical home on clinical quality, patient experiences, clinician/staff experiences, and health system costs. A Patient-Centered Medical Home Evaluators' Collaborative is under way to encourage investigators to work together to reach consensus on a core set of standardized measures that will facilitate cross-study comparisons.

Measuring Medical Homes

Developing metrics to recognize and monitor medical homes is an ongoing process that was kicked off by the National Committee for Quality Assurance (NCQA) in 2007. According to NCQA's national measures, to qualify as a patient-centered medical home a practice must demonstrate proficiency in at least five of the following 10 areas:

- written standards for patient access and patient communication;
- use of data to show they are meeting this standard;
- use of paper-based or electronic charting tools to organize clinical information;
- use of data to identify patients with important diagnoses and conditions;
- adoption and implementation of evidence-based guidelines for three conditions;
- active support of patient self-management;
- tracking system to test and identify abnormal results;
- tracking referrals with paper-based or electronic system;
- measurement of clinical and/or service performance by physician or across a practice; and
- reporting performance across the practice or by physician.

These measures, which were created in collaboration with the four primary care specialty societies, offer an excellent starting point in the process of developing comprehensive medical home standards. With Fund support, NCQA continues to develop and test additional measures that would make the standards more patient-centered and inform future iterations of the measurement set. Areas under development include excellence in patient experience, shared decision-making, family and community involvement, coordination of primary care and specialty physicians, functioning of the staff as a team, and services to address limited English proficiency.

Another key aspect of the medical home model is reforming physician payment to strengthen and reward primary care. Current reimbursement is biased in favor of procedures, such as surgery or imaging, and does not adequately pay for time spent with patients to take their medical history or follow up after the appointment. For successful implementation, primary care practices would submit to a voluntary and objective qualification process to be recognized as a medical home. In exchange, the medical home would be supported with an enhanced or additional payment to support the improved care management, infrastructure, and care coordination. Rather than following a strictly fee-for-service model, purchasers in the Bridges to Excellence Medical Home Initiative, for example, will pay primary care physicians $125 a patient if they meet medical home metrics and chronic care guidelines. In the Medicare Medical Home demonstration planned by the Centers for Medicare and Medicaid Services (CMS), physician practices will receive a risk-adjusted monthly care management fee that, on average, ranges from $40.40 to $51.70 per member per month, depending on the capacity and infrastructure of the physician practice. Such financial support should help bolster the field of primary care as well as improve care. Today, primary care physicians are undercompensated relative to specialists.

Encouraging the adoption of medical homes in small practices and large systems will require national cooperation and federal support for infrastructure, such as health information technology and health information exchanges. With better information technology, practices will have enhanced capacity to summarize the needs of their patients, identify patients who are overdue for appointments, obtain feedback from patients through e-mail and Web portals, or review test results remotely. However, technology is just a tool, and unless the information generated is used to better meet the needs or preferences of patients, it is a disruption that does not improve care.

Multipayer, public–private demonstrations—and there are several getting started—will offer the best glimpse at how practices and patients respond to the medical home. According to a survey by the National Academy for State Health Policy, 31 states are exploring the medical home concept for their Medicaid enrollees. To build more robust experiments, CMS should join commercial and Medicaid payers in these demonstrations.

Getting on the Path to High Performance

The patient-centered medical home can play an integral role in improving quality in the health care system. But we must pursue a number of policies simultaneously. The Commonwealth Fund's Commission on a High Performance Health System has outlined five strategies for high performance:

- extending affordable health insurance to all;
- organizing care to ensure accessible, patient-centered, coordinated care;
- aligning financial incentives to enhance value and achieve savings;
- meeting and raising benchmarks for high-quality, efficient care; and
- ensuring accountable national leadership and public/private collaboration.

The Commission envisions a care system where patients have personal providers who know them, serve as advocates to help them get needed care, help coordinate care, and are accountable for the best possible health outcomes and prudent use of resources. Toward this end, the Commission recommends the following policies:

- **New Per-Patient Medical Home Payment**
  Qualified providers who elect to participate in the program would receive a per-member, per-month medical home fee, in addition to all currently covered fee-for-service payments. The amount of the per-member, per-month payment would vary depending on the severity of illness of the enrolled patient.
- **Qualifications for Medical Home Status**
  To qualify for participation in the program and for the medical home payment, primary care providers

would need sufficient capacity. Qualifying factors would include:

- → providing enhanced access (e.g., 24-hour coverage, timely appointments);
- → using information technology to improve patient care (e.g., electronic health records with registries, reminders, e-prescribing, and clinical decision support);
- → offering care management and care coordination services; and
- → reporting quality and patient experience measures.

- **Incentives for Patients**
  Positive incentives would be provided to encourage patients to enroll and designate a primary care practice. Beneficiaries would receive a discount on their premiums, have their deductibles waived, or enjoy lower cost-sharing for primary care as an incentive to designate a primary care medical home.

- **Incentives for Providers**
  Physicians would also participate in the incentive program, under which savings in total health spending for enrolled groups would be shared by patients, providers, and payers. Participating providers could receive their share of savings as year-end bonuses based on their performance as judged by clinical quality and patient experience. Evaluation measures might include, for example, the proportion of patients who are up-to-date with recommended preventive services and percentage of patients with chronic conditions who are adequately controlled.

This year we have a historic opportunity to fundamentally change health care in the United States. We hope our country will seize this chance to improve access and care, and lower costs, so that the health system will work well for everyone for generations to come.

June 22 , 2009

Cooperative Health Care: The Way Forward?

By Karen Davis

As part of the health reform debate, Senator Kent Conrad (D-ND) has proposed forming nonprofit cooperatives to provide health insurance coverage at low cost. While the details are still being fleshed out, an examination of the history of cooperative health care—which has often also featured an integrated care delivery system—reveals some important lessons that apply to the current policy discussion. The three major takeaways are:

1. Local cooperative health organizations can and do provide top-quality integrated, coordinated care, but they have faced formidable obstacles in their formation, operation, and growth.

2. A national organization with authority to purchase health care at reasonable rates is integral to controlling costs successfully.

3. Transforming health care delivery in the United States into a mission-driven, patient-centered, value-enhancing system of care will require incentives for physicians to practice in health care organizations that are accountable to patients and consumers, as well as *dis*incentives for continuing our current fragmented fee-for-service system.

History of Health Cooperatives

According to sociologist and writer Paul Starr, the first health care cooperative was formed in 1929 by Dr. Michael Shadid in Elk City, Oklahoma—my home state. This pioneer faced immense obstacles, including opposition from the county medical society. Nonetheless, with the help of the populist Oklahoma Farmers' Union, he succeeded in securing a loan to build a hospital and creating a prepaid insurance plan. Dr. Shadid's philosophy was that the government's role was to subsidize the poor's enrollment fees. Consumers would manage the business operations, but doctors would remain in control of the professional aspects of care.

Dr. Shadid's success inspired others to form regional health cooperatives that provide networks of health care plans and providers. Indeed, the two most successful modern examples of cooperative health systems are HealthPartners, based in the Twin Cities of Minnesota, and the Seattle-based Group Health Cooperative. Both of these consumer-governed health care organizations serve more than 500,000 members in a wide geographic region. Along with insurance, they directly provide health care services through a nonprofit integrated delivery system that owns its own hospitals and has its own dedicated multispecialty physician group providing integrated, coordinated care of high quality while making prudent use of resources. Although both organizations have encountered obstacles throughout their 50-plus-year histories—among them, the opposition of organized medicine and internal tensions between physicians and consumer-governed boards—they exist today as examples of health care organizations that deliver high-value care. New case studies of the two organizations, now available on the Commonwealth Fund Web site, offer insight into their strategies.

There is no question that these shining examples of cooperative health represent a model for the financing and delivery of health care, as do similar nonprofit—though not consumer-governed—integrated delivery systems, such as Geisinger Health System, Intermountain Healthcare, and Kaiser Permanente. The question is: What would it take to go from our current system of health care to a national delivery system that has the mission, values, capacity, and operational systems and strategies of these organizations?

The cooperative landscape is certainly littered with failures. Group Health Association in Washington, D.C., for example, failed in the early 1990s after intense conflicts between consumer-led management and the medical group. Another large cooperative, Group Health Inc. (GHI), in New York City, is preparing to convert to for-profit status. Surrounded by a marketplace that provides substantial rewards to for-profit insurance and fee-for-service care, these organizations have moved away from the original consumer-led governance structure and mission.

This cooperative health care experience—both successful and unsuccessful—underscores the difficulty of reconciling the public's desire for low-cost, high-quality care with physicians' desire for professional autonomy and control of health resources. It is also difficult to maintain the ideals of consumer-governed health care in the face of a marketplace that rewards volume over value. There are even legal obstacles, erected by those favoring the current marketplace incentives. In response to the development of cooperatives owned by their members/patients, a number of states enacted laws that make it illegal for a physician to be employed by a nonphysician, effectively precluding cooperative health plans.

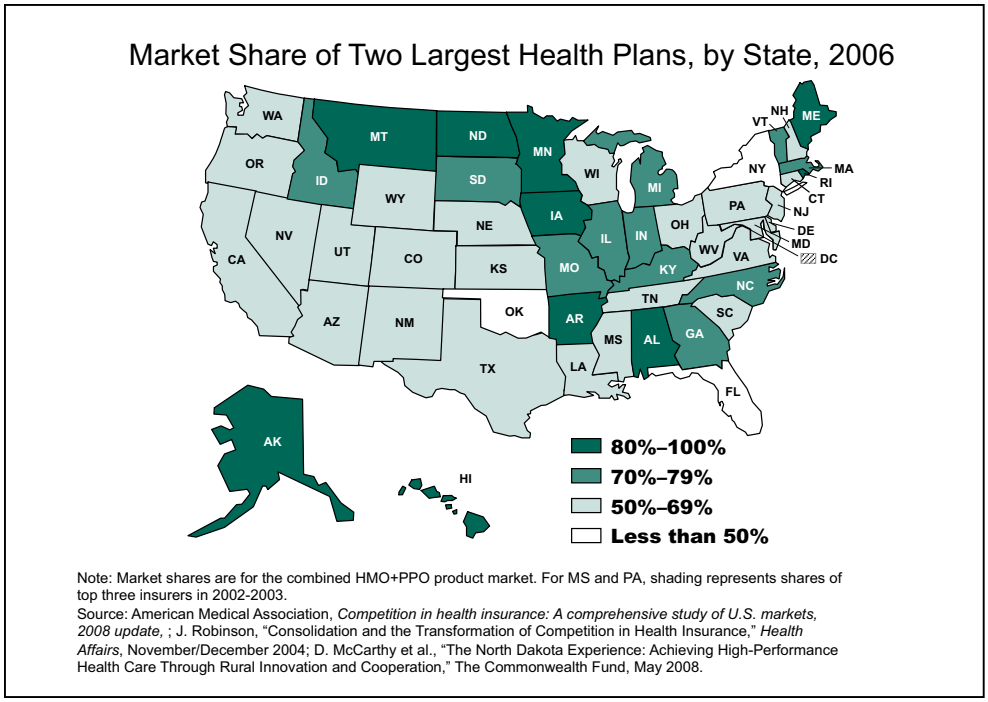
The key to the success of cooperatives in other sectors of the economy has been the ability to leverage purchasing power to obtain lower rates—for electricity, as an example. Rural electricity cooperatives took root during the Great Depression following establishment of the Tennessee Valley Authority (TVA) Act in May 1933. This act authorized the TVA board to construct transmission lines to serve "farms and small villages that are not otherwise supplied with electricity at reasonable rates." The idea of providing federal assistance to accomplish rural electrification gained ground rapidly when President Roosevelt took office in 1933 and launched his New Deal programs. On May 11, 1935, Roosevelt signed Executive Order No. 7037, establishing the Rural Electrification Administration (REA). A year later the Rural Electrification Act was passed, and the lending program that became the REA got under way.

Most rural electrification is the product of locally owned rural electric cooperatives that got their start by borrowing funds from REA to build lines and provide service on a nonprofit basis. Today the REA is the Rural Utilities Service and is part of the U.S. Department of Agriculture. An important part of the history of electric cooperatives has been the development of power marketing agencies (PMAs). In 1937, the federal government established the first PMA, the Bonneville Power Administration. The government proceeded to form four more PMAs to market the power generated at 133 federal dams across the country. The federal law that governs PMAs gives preference in the sale of power at cost to public bodies and electric cooperatives. The availability of low-cost power to electric cooperatives has promoted economic development and has offset the cost of serving sparsely populated areas.

For cooperative health care to slow the growth in health care costs and achieve savings, a cooperative insurance organization would need the authority to purchase care on favorable terms. This might be accomplished by guaranteeing that the cooperative health plan can obtain the lowest price charged to the most favored customer. Today, commercial insurers dominate the market in most geographic areas, and, with the exception of three states, the two largest health insurance plans in each state account for 50 percent or more of all private insurance enrollment.

These plans use their purchasing clout to obtain discounted rates in negotiations with local health care providers. In local markets where there are dominant health care providers, hospitals and other providers are able to push back and demand higher rates. But while multiple negotiations among multiple insurers and multiple providers consume significant administrative costs, the result is not a competitive market price applicable to all customers, but rather favorable rates for the most powerful participants in the negotiations.

Another way to leverage purchasing would be to have a national cooperative organization negotiate provider prices on behalf of all customers. This is the model used by Germany's "sickness funds." These membership cooperatives, which have consumer boards, conduct negotiations with their regional counterpart provider organizations on behalf of all patients for standard health benefits. In the U.S., such a process could be entrusted to a national "Health Value Authority" and applied to all health plans participating in an insurance exchange. A nonprofit, consumer-driven entity acting in the public interest would then manage payment and delivery system reform, rather than leave such



Note: Market shares are for the combined HMO+PPO product market. For MS and PA, shading represents shares of top three insurers in 2002-2003.
Source: American Medical Association, *Competition in health insurance: A comprehensive study of U.S. markets, 2008 update,* ; J. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, November/December 2004; D. McCarthy et al., "The North Dakota Experience: Achieving High-Performance Health Care Through Rural Innovation and Cooperation," The Commonwealth Fund, May 2008.

reforms to the market powers of insurers or providers in a given geographic area or to a political process influenced by special interests.

Transforming American Health Care

Two different strategies for revamping the health insurance system have now been proposed by members of Congress: a cooperative strategy and a public insurance plan. A cooperative health strategy could establish a national cooperative organization to transform insurance provision and support the development of local cooperative health care delivery systems. A national organization, such as a Health Value Authority, could provide a variety of supporting functions, such as making grants and loans to start local cooperative health care delivery systems and providing actuarial technical assistance and other needed support. Such a national organization could also be given the authority to negotiate provider payment rates and methods on behalf of all insurers—public and private—and eliminate the administrative waste now generated by thousands of individual-provider price negotiations. In addition, it could institute new methods of payment, changing the marketplace from one that competes on providing greater volume of services to one that rewards better outcomes for patients and more prudent use of resources. National authority might be needed to override state laws that restrict cooperative health care delivery systems or cooperative health insurance products.

This strategy would break new ground and lead to a health system that provides high-quality, high-value care. The role of insurance would be to pool risk broadly and restructure local competitive markets so as to align incentives with the provision of high-value care. The long history of establishing local cooperative health care delivery systems certainly raises awareness about how quickly such change could be effected. And the responsibilities, authority, and structure of a national Health Value Authority would require careful thought, time, and expertise to develop and implement.

The second option is to create a new public health insurance plan, offered by the U.S. Department of Health and Human Services (HHS), that adopts new value-based payment methods, builds on the current Medicare network of hospitals and physicians, and competes with private insurers within a national health insurance exchange. Even subject to the same rules as private insurers regarding benefits, coverage, and other standards, such a plan could offer a premium that is 15 to 25 percent lower than premiums now offered in the individual and small business market, depending upon

whether providers are paid at Medicare levels or at some midpoint between commercial and Medicare levels.

HHS could also be given the authority to modify rates for individual services. This might involve reducing rates for overpriced services, which have contributed to the enormous growth in volume of services documented by the Dartmouth Atlas and, more recently, by Atul Gawande in his influential *New Yorker* article. Savings from reducing prices for overpriced services could be shared between the federal budget and a bonus pool for high-performing providers.

Payment rates under the public health insurance plan could also be made available to private plans, with the same carrots and sticks for physicians to participate in the network. Competition between a public plan and private plans featuring a level playing field for provider payment could achieve significant economies both initially and over time, yielding up to $3 trillion in health system savings between 2010 and 2020.

Under such reform, most providers would continue to experience rising revenues, albeit at a slower rate. Covering the uninsured generates new revenues for providers and improved benefits reduce bad debts. If a public plan paid providers at a point midway between Medicare and commercial rates, physician revenue would grow on average at an annual rate of 4.3 percent over the 2010–2020 period and hospital revenue would grow at an annual rate of 5.3 percent—well within the growth rate promised by an industry coalition in a letter to President Obama.

A People-Centered, Value-Enhancing Health System

As President Lincoln emphasized in his Gettysburg Address, the U.S. is guided by the philosophy of "government of the people, by the people, and for the people." What is needed in health care is a similar philosophy: a health system that is truly for the people. Redesigning health care so that it puts people front and center and ensures that care is patient-centered, accessible, and coordinated should be the fundamental goals of health reform.

Ultimately, it is the public that pays for health care, whether through the direct costs of premiums and health services, forgone wages from rising premiums in employer-sponsored health plans, or higher taxes to support Medicare, Medicaid, and other public health programs. Health reform needs to ensure accountability and value for the resources that are entrusted to health care organizations and providers for the care of patients.

Two choices have been put on the table—a cooperative health care system designed and governed by consumers, and a public health insurance plan designed and offered by government acting in the public interest. Both could work if they are given sufficient authority to act in the public interest. Adopting a new cooperative health system would be difficult, and its long-term impact and sustainability would be uncertain. Still, both alternatives embrace a philosophy of people-centered health care and both are worthy of debate and consideration. Incorporating elements of both into health reform may well point the way forward.

July 17, 2008

Headed in the Wrong Direction: The 2008 National Scorecard on U.S. Health System Performance

By Karen Davis

Belief in economic and scientific progress is deeply engrained in the American way of life. As residents of a "can do" nation, Americans expect that our children will be better off than their parents, and that scientific breakthroughs will eventually conquer disease. Evidence that health care in this country is slipping backward is, therefore, deeply troubling.

Despite the best efforts of millions of talented and dedicated health care professionals, The Commonwealth Fund's latest Commission on a High Performance Health System *National Scorecard on U.S. Health System Performance* demonstrates that, in fact, we are losing ground. The first *Scorecard* was published in 2006. The new *Scorecard*, published this month, finds disturbing evidence that the health system is on the wrong track. In nearly every category measured, the health system performs worse than two years ago—scoring just 65 out of 100 across 37 indicators, where 100 represents not what is ideal but what has actually been achieved in some places for some groups of people.

The *Scorecard* takes a broad look at how well the U.S. health care system is doing, where improvements are needed, and what examples of good care exist that could serve as models for the rest of the country. It looks at specific issues: Do people have access to the health care they need? Are they getting the highest-quality care, and are we spending money and using health care resources efficiently?

One of the primary reasons for the system's poor performance is worsening access to care. In 2007, more than 75 million adults—42 percent of all adults ages 19 to 64—were either uninsured or underinsured during the year, up from 35 percent in 2003. This means that millions of Americans are unable to get the care they need.

The *Scorecard* also found evidence that the billions spent on U.S. health care—far more than any other industrialized country—are often squandered on administrative costs, inefficient systems, wasteful care, or treatment of preventable conditions.

The U.S. also failed to keep up with advances in health outcomes, falling from 15th to 19th among industrialized nations in terms of the number of premature deaths that could potentially have been prevented by timely access to care.

The good news? There have been some gains in the quality of care. Performance on a key measure of patient safety—hospital standardized mortality ratios, which were targeted in the Institute for Healthcare Improvement's "100,000 Lives campaign"—improved significantly, by 19 percent from 2000–2002 to 2004–2006. Moreover, hospitals are increasingly meeting evidence-based treatment guidelines, for which data are collected and reported on a Medicare Web site. Rates of control of two common chronic conditions, diabetes and high blood pressure, also have improved significantly. These measures are publicly reported by health plans, and physician groups are increasingly rewarded for improving treatment of these conditions. So improvement is possible, but it takes leadership, concerted action, and monitoring of progress.

If the U.S. health system achieved benchmark levels of performance, there would be real benefits in terms of health, patient experiences, and savings. For example:

- Thirty-seven million more adults would have an accessible primary care provider, and 70 million more

adults would receive all recommended preventive care.

- 100,000 fewer people would die from causes that could have been prevented by good care.
- The Medicare program could potentially save at least $12 billion a year by reducing readmissions or reducing hospitalizations for preventable conditions.
- If we could lower the administrative costs of health insurance to the level found in Germany, which like the U.S. has a blended public–private health system, we could save $51 billion a year. Reaching levels achieved in the best performing countries would save an estimated $102 billion per year.

These and other findings make a compelling case for change in the way U.S. health care is financed, organized, and delivered. A new Presidential administration in 2009 will provide a historic opportunity to change direction. A comprehensive strategy that simultaneously aims to ensure health insurance for all, improve quality, and achieve greater efficiency is needed to close gaps in performance. The goal should be a 2010 *National Scorecard* that lives up to the best of what is possible with American ingenuity and the considerable resources invested in our health sector.

October 9, 2008

Reducing Preventable Deaths Through Improved Health System Performance

By Stephen C. Schoenbaum, M.D., M.P.H.

In its initial Framework Statement, the Commonwealth Fund Commission on a High Performance Health System stated that "a high performance health care system is one that has the overarching mission to help everyone live as long, healthy, and productive lives as possible…." But research from The Commonwealth Fund and others shows that the U.S. is not reducing its rate of "mortality amenable to health care"—or potentially preventable deaths—as quickly as other industrialized nations. And some recent studies point to shocking declines in the U.S. on a related measure, life expectancy, as well as rises in infant mortality rates.

Poor performance on these measures points, in large part, to flawed preventive care that fails to identify underlying conditions, such as hypertension, that can lead to potentially fatal diseases or to help people living with chronic disease stay as healthy as possible. For example, Fund research has found that, as of 2005, adults in the U.S. received only half of the recommended screening and preventive care for their age group.

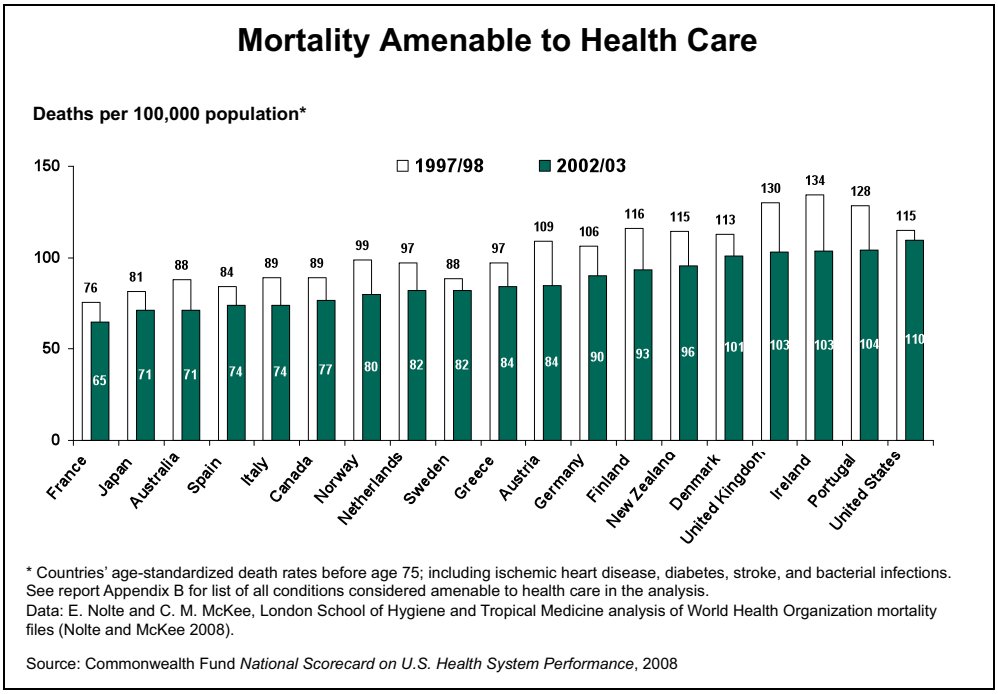
Understanding the Differences in Rates of Preventable Deaths

On average across Organization for Economic Cooperation and Development (OECD) countries, mortality amenable to health care comprises about 23 percent of total mortality for men under age 75 and 32 percent of total mortality in women in this age group. It is a worthy target for reduction. Because of its significance, mortality amenable to health care was one of the measures of long, healthy, and productive lives used in the Commission's 2006 and 2008 *National Scorecard*s on health system performance.

As Ellen Nolte, Ph.D., and C. Martin McKee, M.D., D.Sc., of the London School of Hygiene and Tropical Medicine reported in a Fund-supported study in *Health Affairs*, mortality amenable to health care in the U.S. dropped from 115 to 110 per 100,000 between 1997–1998 and 2002–2003. But the decline in other countries over the same period was greater—and the U.S. went from 15th to 19th in relative position among 19 developed countries in the OECD.

Within the U.S., there is tremendous variation on this measure. The Commonwealth Fund's State Scorecard revealed that, while some states have achieved results better than the top countries, others have results that are significantly worse than the national average.

Many people believe that differences in mortality rates simply reflect differences among the populations of countries or states, such as genetics or diet and lifestyle. Indeed, there is little question that measures of overall mortality are heavily influenced by factors other than health care. But the researchers measuring mortality amenable to health care minimize the influence of these factors by setting age limits. The measure includes only deaths under age 75, and is further restricted to deaths at younger ages for specific conditions, such as under age 50 for diabetes, 45 for leukemia, and 15 for conditions such as whooping cough. Researchers also adjust for the inability of medicine to prevent all deaths from certain conditions. For example, since evidence suggests that only up to half of premature deaths from ischemic heart disease (IHD) can potentially be eliminated by health care, the measure includes only half of the IHD deaths.



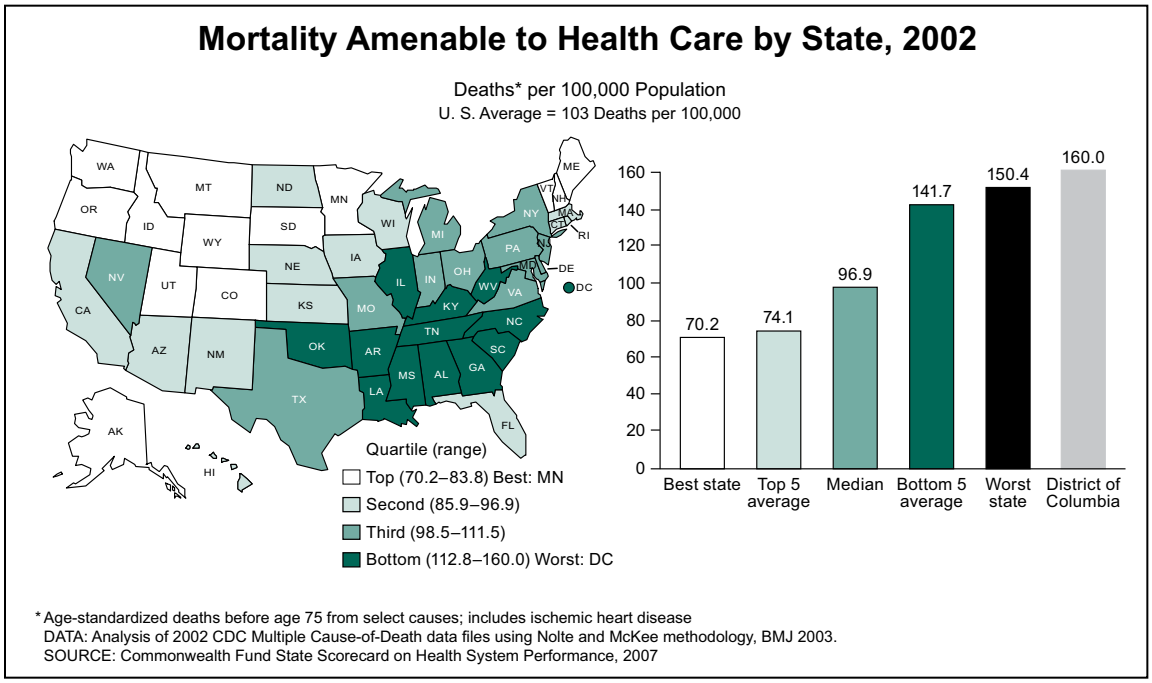
* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. See report Appendix B for list of all conditions considered amenable to health care in the analysis.
Data: E. Nolte and C. M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization mortality files (Nolte and McKee 2008).

Source: Commonwealth Fund *National Scorecard on U.S. Health System Performance*, 2008

The measure may still reflect factors other than health care differences. But that said, the death rate from amenable causes among women under age 75 in 2002–2003 was 96.41 per 100,000 in the U.S., versus 68.15 in Canada and 57.40 in France. It appears that this is not the best we can do.

The Role of Disparities

Recent articles have drawn attention to other variations in mortality data within the U.S., in particular data on life expectancy that show increasing inequality among socioeconomic groups and geographic regions. The reasons for the inequality in life expectancy are not clear, though factors such as higher smoking and obesity rates, which



* Age-standardized deaths before age 75 from select causes; includes ischemic heart disease
DATA: Analysis of 2002 CDC Multiple Cause-of-Death data files using Nolte and McKee methodology, BMJ 2003.
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

contribute to chronic disease, have been cited. An April 2008 study on cross-county mortality disparities in the U.S. found that increasingly poor life expectancy in certain counties in the Deep South and Appalachia was caused by increasingly higher mortality from lung cancer, chronic obstructive pulmonary disease, and diabetes, among other non-communicable diseases. Christopher Murray, a coauthor of the study and director of the Institute for Health Metrics and Evaluation at the University of Washington, told the *Wall Street Journal* that, because chronic diseases are often preventable, this finding was both discouraging and encouraging.

Additionally, Centers for Disease Control and Prevention data reveal that the nearly decade-long decline in U.S. infant mortality rates has now stalled, a reflection of poor early prenatal care, among other problems. Most recent infant mortality rates are a little higher than in the past, and African-American newborns are 2.4 times as likely to die as white infants. While the link between race and infant mortality has not been established with certainty, poverty, poor access to health care, and dietary differences are likely to contribute.

A Need for High Performance

The data cited here underscore the need to implement health reform in the U.S. so that all Americans can have excellent access to excellent care.

The Commonwealth Fund's Commission on a High Performance Health System has developed five key strategies for achieving broad performance improvement:

1. Extend affordable health insurance to all.
2. Align financial incentives to enhance value and achieve savings.
3. Organize the health care system around the patient to ensure that care is accessible and coordinated.
4. Meet and raise benchmarks for high-quality, accessible care
5. Ensure accountable national leadership and public/private collaboration.

First, we should make affordable care available to all by maintaining the employer-based system, as well as expanding public programs and offering health insurance through a national health insurance exchange. It is critical that Americans' health insurance be comprehensive, covering all necessary care, including preventive care, with little or no cost-sharing with individuals.

We also must reform our payment system, as fee-for-service incentives reward more services and not necessarily better care. Good preventive care, for example, requires not just a screening test, but also services that are not currently reimbursed such as outreach and follow-up when a test is positive.

Outreach and follow-up care are facilitated when patients have a medical home that serves as a regular source of care and coordinates care for people. Medical homes that are paid per patient can encourage preventive care by sending electronic reminders of screening visits—reminding patients that it's time for their cholesterol check, for example. We also should strengthen the quality of care offered by providers, particularly safety net providers, by ensuring they meet benchmark goals of performance.

Finally, national leadership is needed not only to establish prevention guidelines but to implement them better, develop incentives for creating and sustaining medical homes, and support better care with infrastructure such as health information technology. At that point, we can see whether we are able to catch up to the other industrialized countries that have long since passed us by in terms of outcomes such as amenable mortality, life expectancy, and infant mortality. Our poor performance on these measures should urge us to start work to improve health system performance as soon as possible.

January 26, 2009

Health Information Technology: Key Lever in Health System Transformation

By Karen Davis and Kristof Stremikis

As President Obama and the new Congress embark on an ambitious agenda to reform the American health care system, the need to develop a national policy to encourage the spread of health information technology (IT) is resurfacing as a key issue. The health care proposals from both the Obama–Biden campaign and Senator Max Baucus (D–Mont.) call for expansion of health IT as a means of facilitating quality reporting and improvement activities, empowering individual patients, and expanding provider access to evidence and clinical decision-support tools. More recently, significant investment in national IT infrastructure was put forward as an integral component of the economic stimulus bill, which aims to expand employment while increasing efficiency and lowering costs in the long run.

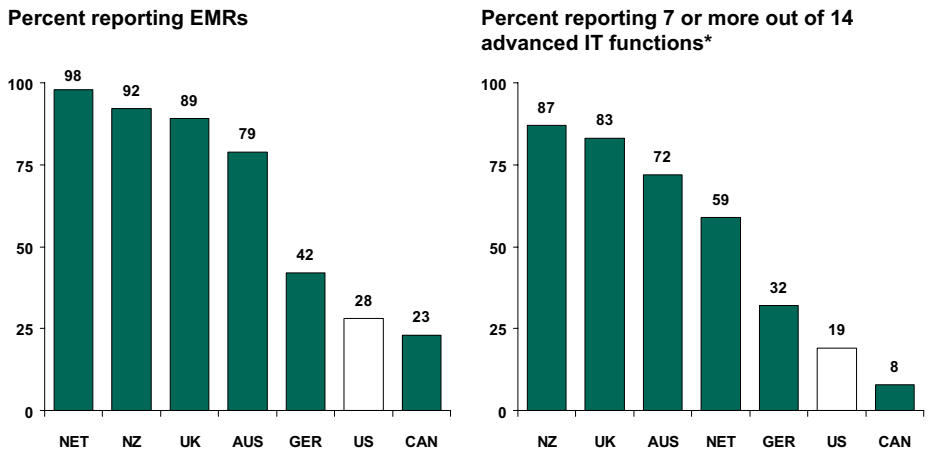
Still, modern IT is not a panacea for all that ails health care in this country. Data from high-performance health systems within the United States and throughout the broader international community show that investments in health IT must be supported by other actions, including financial incentives to make a provider case for adoption and use, and standards set by government. IT investments must also be coupled with strong commitments to performance improvement.

The Evidence Base and Business Case for Health Information Technology

U.S. health providers have been slow to adopt health IT, in part, because of concerns about its value and the costs of implementation. Analysis of the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians demonstrates that the United States has fallen far behind the Netherlands, New Zealand, the United Kingdom, Australia, and Germany on a number of measures related to the utilization of health IT. The contrast between the United States and the Netherlands is particularly stark, with 98 percent of Dutch primary care physicians reporting the use of electronic medical records compared with only 28 percent of their American counterparts. This general pattern persists when examining the prevalence of other IT functions such as electronic prescribing, decision support, and computerized access to test results.

Evidence from the literature demonstrates that investments in health information technology show substantial promise for improving the quality of care that patients receive. Recent analysis of the 2006 Commonwealth Fund Survey of Primary Care Physicians that Commonwealth Fund colleagues and I published recently in the professional journal *Health Policy* confirms that advances in information technology are making it easier for physicians to provide coordinated, high-quality care by streamlining many crucial tasks, including sending patient reminders, creating disease registries, prescribing and refilling medications, and viewing lab results. Doctors with a high level of health IT functionality were also more likely to think the health system works well and be satisfied with the practice of

Only 28 Percent of U.S. Primary Care Physicians Have Electronic Medical Records; Only 19 Percent Have Advanced IT Capacity



* Count of 14: EMR; EMR access other doctors, outside office, patients; routine use electronic ordering tests, prescriptions; access test results, hospital records; computer for reminders, Rx alerts; prompt tests results; and easy to list diagnosis, medications, patients due for care.
Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

medicine. In addition, Fund-sponsored work led by Ruben Amarasingham, M.D., M.B.A., of the University of Texas Southwestern Medical Center has shown that hospitals with more advanced information technology capacity have fewer complications and decreased mortality rates.

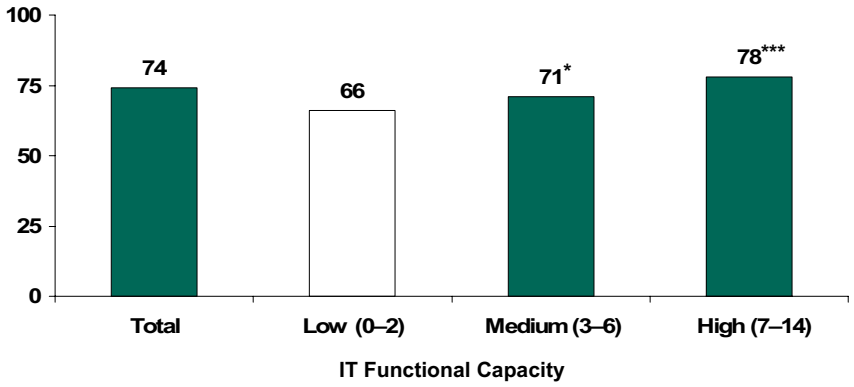
Several studies have also suggested that a business case can be made for the adoption of health IT, both at the facility level and within the health system as a whole. Amarasingham and his colleagues' findings importantly show that utilizing IT to automate test results, order entry, and decision support was not only associated with better quality but also lower average adjusted costs for hospital admissions and lower mean hospital costs for a variety of clinical conditions, including heart failure and coronary artery bypass grafting. Computerized decision support was particularly effective at generating savings. Higher degrees of decision support automation were associated with lower average adjusted costs of $538 for all conditions. If these reductions were realized among the 37 million hospital admissions in the United States in 2005, facilities across the country would stand to save almost $20 billion a year.

The Commonwealth Fund report, *Bending the Curve*, put the aggregate system-wide savings of promoting health information technology at $88 billion over 10 years. The authors estimated that the cost reductions would result from a lower rate of medical errors, more efficient use of diagnostic testing, more effective drug utilization, and decreased provider costs, among other improvements. Additional savings would likely flow from better care coordination among multiple providers—and improved chronic care management—that would lead to a decrease in provider utilization and better health outcomes. Financial benefits accrue to all payers, with investments in health IT estimated to result in substantial cumulative net savings to all levels of government and households over 10 years and cumulative savings to private insurers after 11 years.

Health Information Technology in High Performance Health Systems

While technology has the potential to improve care, save lives, and reduce cost, data from high performance health systems within the United States and the broader international community show that investments in health IT must be made in conjunction with performance improvement activities. Analysis of Geisinger Health System, a nonprofit integrated delivery network in Pennsylvania on whose board of directors I serve, shows that information technology is a crucial component of that organization's efforts to empower consumers and enhance value. Use of electronic health records within Geisinger's *ProvenHealth Navigator* medical home initiative improved quality while decreasing costs by 4 percent per enrollee during the first phase of implementation. Similarly, utilization of health IT

Physicians with Advanced IT Capacity in Seven Nations Are More Likely to Report Being Well-Prepared to Provide Optimal Care for Patients with Chronic Conditions



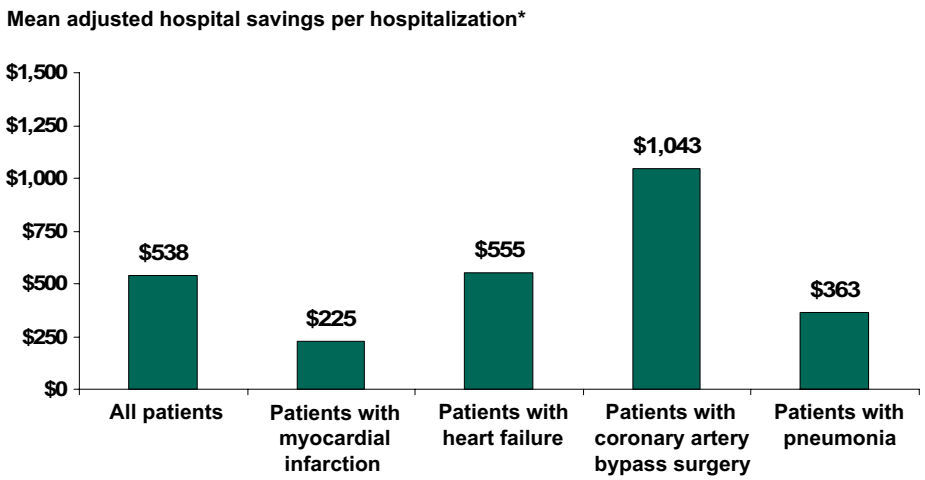
Note: Adjusted percentages based on logit models; Difference from practice with low IT capacity is statistically significant: *** p<0.001, * p<0.05.
Data: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
Source: K. Davis, M. M. Doty, K. Shea, and K. Stremikis, "Health Information Technology and Physician Perceptions of Quality of Care and Satisfaction," *Health Policy* (published online Nov. 25, 2008, in advance of print).

in Geisinger's *ProvenCare* acute episodic payment program helped decrease readmission rates by 5 percent, while the rate among the Medicare control population increased.

The Geisinger experience shows that realizing the full benefit of electronic health records requires a strategy that leverages technological innovation while simultaneously realigning provider incentives and encouraging greater organization of care delivery. This approach parallels that employed by Kaiser Permanente (KP), where investment in health IT was done concurrent to key changes in care process design and the introduction of a performance-based, patient-centered culture. As a result of these initiatives, more than 2.4 million KP members are now able to check lab results, access health information, and send secure messages to their doctor online. Integrating this functionality with KP's *HealthConnect* inpatient and outpatient care delivery systems has driven higher quality and better clinical outcomes.

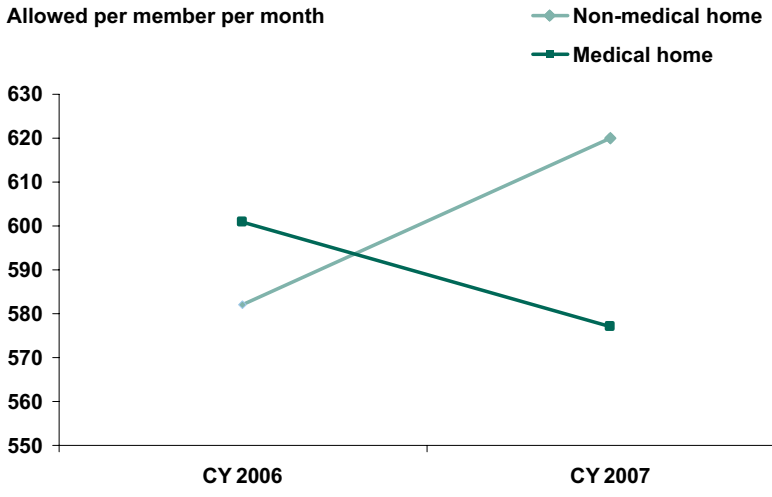
The promulgation of health IT and the establishment of national information exchanges are also key components of high-performance health systems in Denmark and the Netherlands. Upwards of 99 percent of Danish primary care physicians now use electronic health records and e-prescribing. All prescriptions, lab tests, and hospital discharge letters flow through a single electronic portal accessible to patients—and with the permission of patients—to physicians and home health nurses involved in the patients' care. A 10-country study shows the importance of financial incentives, delivery system organization, a standards-setting organization, and peer influence in achieving and sustaining near-universal levels of participation in Denmark. Meanwhile, government funding, an electronic billing mandate, and accreditation of vendor systems all contributed to similar levels of health IT adoption in the Netherlands.

Hospitals with Automated Clinical Decision Support Generate Savings



* Adjusted for patient complication risk; patient mortality risk; and hospital size, total margin, and ownership. Savings associated with a 10-point increase in Clinical Information Technology Assessment Tool subdomain score.
Source: R. Amarasingham, L. Plantinga, M. Diener-West et al., "Clinical Information Technologies and Inpatient Outcomes: A Multiple Hospital Study," *Archives of Internal Medicine,* Jan. 26, 2009 169(2):108–14.

Geisinger Medical Home Pilot Sites Reduce Medical Cost by Four Percent in First Year



Source: G. Steele, "Geisinger Quality—Striving for Perfection," Presentation to The Commonwealth Fund Bipartisan Congressional Health Policy Conference, Jan. 10, 2009.

Advancing the Health Information Technology Policy Agenda

President Obama and Congress must draw on the data and lessons from high-performance health systems as they design policies to encourage the spread of health information technology. Not only does the country need to implement health IT within the context of broader quality improvement, international and domestic experience show that concerted federal action is needed to encourage the spread of health information technology and ensure a substantial return on investment. In a new Commonwealth Fund policy perspective, David Blumenthal, M.D., of the Massachusetts General Hospital proposes five important strategies for federal leaders to consider:

- The federal government should provide financial assistance to safety-net providers and small physician practices without the resources to purchase and implement health IT systems.
- Federal financial support is needed to design and implement information exchange networks in local communities.
- The federal government should support research to improve the capabilities of health IT and further evaluate its effects on health care costs and quality.
- Federal leaders must enact payment reform initiatives that encourage adoption of IT and improve health system performance.
- National regulations and standards are needed to ensure privacy and enhance certification, improving both doctor and patient confidence in the security of electronic medical records and the utility of a national network.

Just as investment in railroads, air traffic control, and interstate highways facilitated economic development and national prosperity in the 20th century, so too will the spread of health IT and the development of a national health information network bring long-run benefits and gains to the nation in the 21st century. It is crucial that our federal leadership move now to harness the power of information technology and put the nation on a path to high performance.

September 16, 2008

The Presidential Candidates' Health Reform Plans: Important Choices for the Nation

By Karen Davis

The presidential candidates have responded to Americans' deep-seated concern about the shortcomings of the U.S. health system with two very different health reform proposals. A new series of articles published on the Web site of the health policy journal *Health Affairs* provides important analyses of the health plans of Senators Obama and McCain that merit close examination. As the articles reveal, the candidates are far apart on what they perceive to be the root causes of system failure and on their overall strategy for fixing a broken sector that consumes 16 percent of the gross domestic product, yet leaves 46 million uninsured and another 25 million working-age adults underinsured.

The September 16 online issue of *Health Affairs* includes a critique of Senator Obama's health reform plan by Joseph Antos and colleagues, a critique of Senator McCain's plan by Thomas Buchmueller and colleagues, and an article by Mark V. Pauly that explores how the candidates' proposals might be combined in a single compromise package.

I believe the kind of scrutiny of both plans that is seen in the *Health Affairs* articles is positive—so that when the public has made its choice, the winning candidate can put his team to work, using the best information available on what reforms are most likely to promote a high performance health system.

Correcting a Cost Estimate

In the interest of helping inform the debate, colleagues at The Commonwealth Fund and I developed a framework for a comprehensive approach to health care reform that is laid out in "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," published in *Health Affairs* in their May/June 2008 issue. To support their argument that Senator Obama's plan is too costly, the critique by Joseph Antos and colleagues cites the estimated costs of the *Building Blocks* proposal, which has several features in common with Senator Obama's plan. However, Senator Obama's proposal differs in important respects—for example, it does not require adults to have insurance and it has not specified the level of income-related premium subsidies or income eligibility levels for Medicaid and the State Children's Health Insurance Program (SCHIP).

The authors' assertion that the *Building Blocks* plan would increase spending by $162 billion if it were operating in 2008 is misleading. The actual net cost to the federal budget in the article is $82 billion in 2008, after allowing for the recapture of funds now subsidizing care of the uninsured, employer contributions to coverage of workers, and assessments on providers that offset their enhanced payments for care of the uninsured and Medicaid beneficiaries. An accompanying issue brief notes how even this cost could be further reduced to $31 billion in 2008 by adopting a series of provider payment and health system reforms that have been supported, in principle, by both Senator McCain and Senator Obama. As a result, the nation could actually *save* $1.6 trillion over 10 years if health expansions are coupled with efforts to reform how the United States pays for health care, invest in better information systems, and adopt initiatives to improve public health. The debate is not furthered by implying that coverage for all Americans is unaffordable. If properly designed, universal coverage could improve overall performance of the health system, enhance value for what we are spending, and assure access to health care for all.

The Underlying Differences

Despite the general nature of the health proposals advanced by the candidates, the *Health Affairs* articles shed light on the issues underlying this debate: how health insurance coverage would be changed, how coverage would be made affordable, and how the delivery of health care services would be affected.

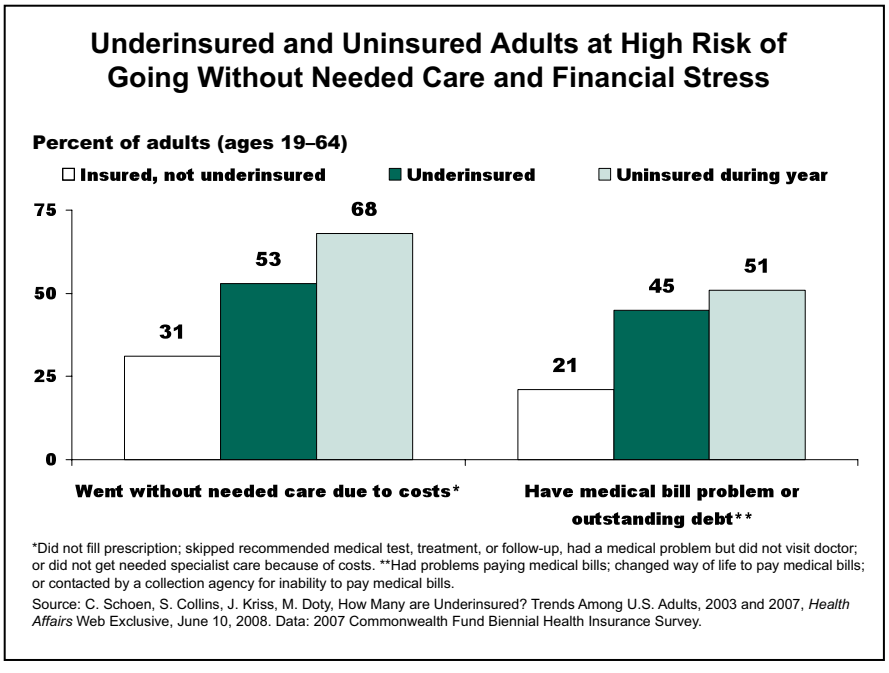
Senator McCain would provide refundable tax credits for the purchase of health insurance coverage—$2,500 for individuals and $5,000 for families. He would also count employer premiums for health insurance as taxable income to families. As a result, some people would pay less than they now pay, and some would pay more. Buchmueller and colleagues estimate that roughly 20 million would lose employer coverage and 21 million would buy individual coverage—for a net reduction in the uninsured of one million. Over time, the numbers of uninsured would grow because the tax credit is indexed to general inflation rather than rising health care costs. Buchmueller's estimates are consistent with recent estimates from the Tax Policy Center at the Brookings Institution and Urban Institute.

By contrast, Senator Obama would provide income-related premium assistance to lower- and middle-income families—although the exact amounts are not specified—and expand coverage under Medicaid and the SCHIP. The Tax Policy Center makes a number of assumptions about these specifics and estimates his plan would cut the number of uninsured roughly in half.

Our *Building Blocks* proposal, which includes a mandate that everyone have health insurance, expands SCHIP to adults and children with incomes below 150 percent of the poverty level, and ensures that no one pays a premium in excess of five percent of income for those in the lowest tax brackets or 10 percent of income in the higher tax brackets. As a result, it covers an estimated 44 million uninsured out of an estimated 48 million uninsured in 2008. Even without offsetting system reform savings, $82 billion in federal budget outlays is an important investment in healthier children and workers, and key to ensuring financial security from medical bills for all families.

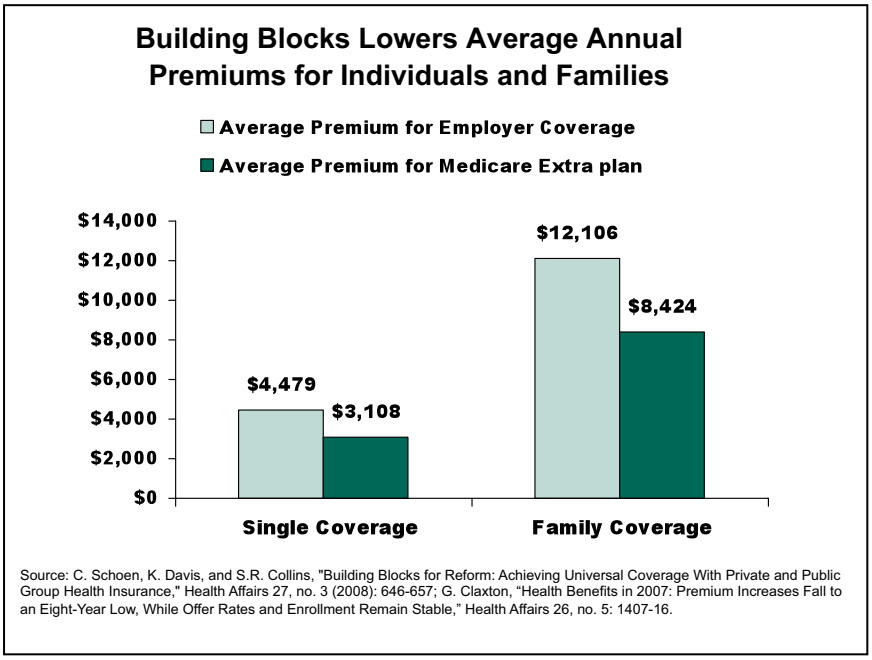
The *Health Affairs* articles also make clear the strategy each candidate would use to make coverage more affordable. Senator McCain would deregulate the health insurance market and permit individuals to purchase coverage in any state. This would provide a larger number of choices and include the option to select cheaper plans with more limited benefits. However, Buchmueller and colleagues point out that Senator McCain's approach could undermine consumer protections and state laws designed to provide a minimum level of coverage—as insurers are likely to charter in states where regulations are scarce, as credit card companies do now.

Senator McCain's philosophy is that consumers making cost-conscious choices would buy policies with leaner benefits. Higher out-of-pocket costs would also lead patients not to seek care for minor conditions. Antos and his coauthors say that the standard for benefits in



*Did not fill prescription; skipped recommended medical test, treatment, or follow-up, had a medical problem but did not visit doctor; or did not get needed specialist care because of costs. **Had problems paying medical bills; changed way of life to pay medical bills; or contacted by a collection agency for inability to pay medical bills.

Source: C. Schoen, S. Collins, J. Kriss, M. Doty, How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007, *Health Affairs* Web Exclusive, June 10, 2008. Data: 2007 Commonwealth Fund Biennial Health Insurance Survey.



Source: C. Schoen, K. Davis, and S.R. Collins, "Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance," Health Affairs 27, no. 3 (2008): 646-657; G. Claxton, "Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrollment Remain Stable," Health Affairs 26, no. 5: 1407-16.

Senator Obama's federal plan—now modeled on the plan available to members of Congress—should be reduced in order to hold down the costs of premiums and federal subsidies. But a skimpier plan is not the answer. A recent Commonwealth Fund report found that low- and even middle-income families are already experiencing difficulty paying medical bills and those with accumulated medical debt are rising. In 2005, 34 percent of adults ages 18 to 64 said they had trouble paying medical bills or had accrued medical debt; by 2007, 41 percent of adults reported such problems.

Buchmueller and colleagues also note that coverage in the individual market typically costs $2000 more than employer coverage offering the same benefits. Pauly argues that many working families may prefer to keep coverage from employers, which generally has lower administrative costs, and suggests a compromise plan that would retain employer coverage but cap the amount of the premium excluded from income taxes.

Senator Obama has a different strategy for making coverage affordable. He would offer a public plan as well as private insurance plans through a national health insurance exchange and set rules for the sale of private insurance—such as requiring private insurance to cover healthy and sick enrollees on the same basis. Private plans would have a maximum ceiling on the share of premium for administrative costs and profits. Antos and colleagues, however, suggest that greater government regulation of insurers could have undesirable consequences and stifle innovation. They are also concerned that increased insurance regulation coupled with the creation of a "fallback" National Health Plan would undermine the employer market. But this has not happened in Massachusetts, which has expanded employer coverage and restrained premium growth since enacting health reform.

Offering small businesses and those without access to employer coverage the option of buying a public plan modeled on Medicare is an intermediate approach. If the government can provide better coverage at lower cost, it would attract employers and the uninsured. Our *Building Blocks* proposal, which like Senator Obama's proposal includes a public plan option, found that actuarial premiums for families in the public plan option were 30 percent below premiums now typical in the employer-sponsored insurance market. Such competition could induce private insurers to compete on quality and efficiency—for example by using networks of hospitals and physicians that provide superior care at lower cost.

Changing the Health System

While the candidates differ markedly on their approach to health insurance coverage, as Mark Pauly describes in his *Health Affairs* article, there are promising features in both McCain and Obama's plans; both would expand the use of health information technology, expand research on the comparative effectiveness of different prescription drugs, devices, and procedures, and support disease management programs. In addition, both Senator McCain and Senator Obama would allow importation of prescription drugs, reducing the costs of drugs.

Most importantly, both Senator McCain and Senator Obama support ensuring that Americans have access to a physician practice or clinic that serves as a medical home that is accessible to patients 24/7. Almost three in four Americans have problems with access to primary care on nights and weekends and even getting an appointment or phone call returned during the day. A medical home would also help patients navigate a complex health care system and be accountable for providing preventive care and chronic disease management. The Commonwealth Fund Commission on a High Performance Health System national scorecard finds that today, only half of Americans are up-to-date with preventive care and millions more do not have their chronic conditions adequately controlled.

To help make the system more responsive to patients, both presidential candidates would change the way doctors and hospitals are paid to reward those that achieve excellence in care and keep patients healthy and out of the hospital, while cutting out unnecessary services that waste dollars and patients' time. A recent Commonwealth Fund survey of the public found that a third had experienced duplicate tests or doctors recommended services or treatment that were of little health benefit.

This is the most important aspect of the reform proposals—but one which has received very little attention. The *Health Affairs* authors are skeptical about magic "silver bullets" that will solve our cost problem, improve quality, and reduce medical errors. But other countries have succeeded in getting better outcomes at lower cost. Candidates should be pressed for more details on how they propose to put the U.S. on the road to a high performance health system—and what approaches now in practice in parts of the U.S. or around the world are workable options for the U.S. as a whole.

The *Health Affairs* articles do highlight some common ground in candidates' aspirations to improve the efficiency of the system and the quality of care. Our hope is that, post-election the focus will turn as quickly as possible to building concretely on the areas of agreement and work from there to achieve the health system reform that the country needs so desperately. We cannot afford to continue on our current course, and indeed must change direction to ensure affordable health care for all Americans.

November 7, 2008

Health Reform in the New Era: Options for the Obama Administration

By Karen Davis

After a long campaign season, and in the middle of an economic crisis, the American public has elected a new President and the 111th Congress. President-elect Obama and Congress will be juggling many competing priorities in 2009, including a historic window of opportunity for health reform.

The public and health care opinion leaders have called for an overhaul of the health care system. The President-elect campaigned on an ambitious health reform agenda—and he has often talked about the stories he heard on the campaign trail about ordinary Americans' struggles with the health care system, as well as his own family's health care experiences. The new President will be assisted in his reform efforts by the new composition of Congress—many members of which also made health care a key message in their campaigns.

The health care system is in crisis. John F. Kennedy, in a speech he gave nearly 50 years ago, noted that when written in Chinese, the word "crisis" is composed of two characters—one representing danger, the other representing opportunity. Perhaps never in our nation's history has this duality been more apparent than in our current quandaries.

In 2007, the number of uninsured stood at 46 million, up 20 percent from 2000. And the number of underinsured—people with health insurance that fails to provide access to care or financial protection—jumped 60 percent over four years, to 25 million in 2007. Today, people are even more worried about keeping their jobs and their health coverage, and are increasingly concerned about their debt, including medical debt. The Commonwealth Fund *2007 Biennial Health Insurance Survey* found that about two-thirds of U.S. working-age adults, or 116 million people, struggled to pay medical bills or pay off medical debt, went without needed care because of cost, were uninsured for a time during the year, or were underinsured.

While President-elect Obama has set forth the substance of his health reform agenda, he has not yet revealed his overarching strategy or precisely when and how he would move on health reform, but there are a number of courses of action open to his Administration.

Defer legislative action while pursuing administrative changes. One option would be to postpone legislative action on health reform while tackling other immediate priorities such as the economy, energy, and Iraq. In the meantime, he could begin a process for gathering input and forging consensus by setting up a Congressional working group or Commission charged with soliciting views from the public, experts, and health care stakeholders, and then developing recommendations for the Administration. The Administration could simultaneously focus on a number of administrative changes that are possible through Executive Order, rule-making, and administrative actions. For example, it could make use of the rule-making authority to support state efforts to maintain and improve Medicaid/State Children's Health Insurance Program (SCHIP) coverage. The advantage of this strategy is that it permits time to sort through difficult issues and find areas of consensus, while addressing other urgent policy priorities. But it also gives opposition time to build.

Make a down payment. At the Democratic Convention, Representative Rahm Emanuel (D-IL), the newly designated Obama White House chief of staff, said the incoming President would need to make a "down payment" on health reform, with the promise of more action to come. So another option would be to show quick action on part of the health reform agenda by enacting a few measures that would garner bipartisan support. This could include,

for example, reauthorization and adequate funding for the SCHIP and building health measures, such as an increase in federal matching funds for Medicaid, into any economic stimulus package. While this approach could have quick results, the major disadvantage is that it postpones fundamental reform, while likely surfacing many of the familiar ideological divides over private insurance and the expansion of public programs.

Use the states as laboratories. If the Administration believes that there is not sufficient consensus to enact health reform at the federal level, the new President might seek funding to permit five to ten states to move forward and test alternative approaches. Such a strategy already has strong bipartisan support. The advantage of this strategy would be the opportunity to learn from testing new approaches on a broad scale. However, a state-based approach to reform means that there will likely be wide variations in insurance coverage, effectiveness, and efficiency—a problem that has plagued the Medicaid program.

Initiate incremental steps in the context of a long-range vision. An alternative that would retain a strong role for the federal government in shaping health reform would be to set forth a long-range vision accompanied by a request for legislative action on some initial reforms. These first reforms could include not only the reauthorization of SCHIP and enactment of health information technology legislation, but other measures aimed at slowing the growth in health care costs such as the creation of a comparative effectiveness institute. The legislation could also authorize the planning and implementation of a national health insurance exchange to offer public and private health plans to small businesses and individuals, as well as a health board to oversee rapid experimentation with and diffusion of payment innovations in Medicare.

Seek a single legislative package with sequenced phases. Another possibility is to include building blocks for reform in a single legislative package that authorizes the flexible roll out of reforms over a six-to-eight year period. A first phase could include the steps outlined above to slow the growth in health care costs and cover low-income children, but with a commitment and the legislative authority to phase in coverage for all. After covering low-income children, subsequent phases could, for example, eliminate the two-year waiting period for coverage of the disabled under Medicare and gradually providing premium assistance for low-and middle-income families to purchase coverage through the health insurance exchange. This approach has the advantage of generating savings in early phases and ensuring those health system reform savings are dedicated to coverage expansions, that sufficient planning is given to implementation of more complex provisions, and that politically popular as well as difficult reforms are considered in their totality and early-on, when the new Administration and Congress have the requisite political capital. Such a sequenced approach to health reform could put the U.S. on a firm path to a high performance health system, yielding better access to care, improved quality, and greater efficiency.

Take early action on comprehensive reform. Finally, president-elect Obama could move swiftly to enact comprehensive health reform in a single legislative package while he has the political capital garnered in a major election victory. If leaders in Congress, such as Senator Kennedy, have a legislative package ready to go, it could be introduced immediately and folded into a major omnibus budget reconciliation act. This would be a bold stroke—one appropriate to the seriousness of the crisis in the health care system and the even more challenging fiscal problems ahead as the baby boom generation reaches retirement.

Windows of opportunity for real health reform do not stay open for long. While the challenge is daunting and the stakes are high, it is imperative that our new federal leadership moves swiftly to change direction and put the U.S. health system on the path to high performance.

February 25, 2009

Compassionate and Challenging Changes in Health Care

By Karen Davis

Last night, President Obama reaffirmed that comprehensive health reform is urgently needed to spark economic recovery, ensure all Americans are able to get the care they need, and lay the foundation for slowing the growth in health care costs. With a recognition that our country's health care and economic fate are intertwined, the president and the 111th Congress have already taken several significant steps toward ensuring affordable health coverage for millions of families and bending the curve of the country's spending on health. Reauthorization of the Children's Health Insurance Program (CHIP) and the passage of an economic stimulus package with health provisions to invest in information technology and research on the effectiveness of medications, devices, and health services represent important down payments on more fundamental change and far-reaching reform.

The president has said that the stories he heard on the campaign trail about people struggling with health care touched his heart. Tragically, there are countless stories of Americans whose lives could have been saved or disabilities averted if they had been able to afford high-quality medical care. In a recent *New Yorker* article, Atul Gawande, M.D., wrote that instances of cruelty in the health care system triggered health reform in many other countries. We may have reached the point where Americans can no longer tolerate the lack of compassion too often faced by those who are sick and unable to pay for care. As a result, many Americans are now willing to think seriously about reforms that will lead to excellent and affordable health care for all.

In response to the health and economic crisis facing the country, the Commonwealth Fund Commission on a High Performance Health System has issued a report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, that provides a strategy for achieving long-term health security and fiscal responsibility. The Commission lays out a framework for responsible and effective use of federal money that ensures funds go to improve access to care, provide savings to families and businesses, and improve the quality and efficiency of care. These reforms will guarantee affordable coverage for all, improve health outcomes, and slow health spending growth by $3 trillion over the next decade. If enacted now, these early investments will pay significant dividends, with coverage, payment, and system reform savings projected to offset the increase in annual federal spending for affordable coverage expansion by 2020.

Compassionate Changes

The Commission's report makes a compelling case for compassionate change in our health system. Most importantly, these reforms would make the health care system work better for patients and families.

Coverage and Care for All

The *Path* proposal would extend affordable health insurance to everyone. The number of uninsured—now at 46 million and projected to rise to 61 million in 2020—would instead fall to an estimated 4 million, or about 1 percent of the U.S. population. Even hard-to-reach individuals would likely qualify for free or low-cost coverage if they became ill and sought health care. An estimated 100,000 lives could be saved through the coverage and system reforms included in the *Path* framework.

Affordable Premiums

The *Path* proposal's approach to coverage builds on what works best in our public–private insurance system. A national health insurance exchange offering a public plan option and a variety of private plans would ensure that everyone has access to affordable coverage. Income-related premium help would be available to make sure that individuals and families in the lowest tax bracket spend no more than 5 percent of income on premiums, and that people in middle-income tax brackets pay no more than 10 percent of income on premiums. For the many Americans facing job insecurity, the insurance exchange would provide a stable and portable source of affordable coverage.

The plan also calls for opening up Medicaid and CHIP to people with incomes below 150 percent of the federal poverty level (under $33,000 for family of four). Those who currently have insurance coverage could keep it.

No Discrimination Against the Sick

Under the *Path* proposal, insurance plans could no longer turn people away because they have an existing medical condition or are considered to be at high risk for one. Nor would individuals with health conditions be charged higher premiums than healthy people. As a result, people in poor health who can no longer work—who today have few prospects of retaining or affording coverage—would no longer fear being without access to insurance coverage and care.

Protection from Ruinous Medical Expenses

The public plan offered through the national health insurance exchange would establish a minimum standard benefit package based on the standard option available to members of Congress and federal employees. Employer plans and plans offered through the exchange would be required to meet this standard of coverage. Deductibles would be $250 per person or $500 per family rather than the $2,000 to $10,000 deductibles found in some health insurance policies today. Preventive services and services required for treatment of chronic conditions would be covered in full.

Family Savings

The average family would save $1,140 in 2010 under the plan, thanks to reforms that reduce administrative costs and promote efficiency in the health care system, as well as those that guarantee financial protection from health care bills. By 2020, the average family would save $2,314 annually, with families of all income levels spending less due to slower cost growth. These dollars would provide substantial relief to families that are now financially strapped because of medical bills and often have to choose between medical care and other basic necessities.

Challenging Changes

While health care providers, employers, taxpayers—and insurers and the health industry—would benefit in important ways, the *Path* framework includes several significant challenges and important decisions for the country to make as it moves down the path to high performance.

Health Care Providers

The most important benefit for physicians is that health insurance for all would help them deliver the care their patients need. No longer would nearly 40 percent of adults under age 65 say they do not obtain needed care because of cost. No longer would patients fail to fill a prescription or take it as indicated, fail to receive a mammogram or colonoscopy or see a specialist, or fail to come back for follow-up care because of trouble paying medical bills.

To help physicians deliver care in a way that works for patients, the *Path* proposal makes changes in the way health care is organized and the way hospitals and doctors are paid. All patients would be encouraged to enroll with a physician or nurse practitioner practice that meets the standards of a "patient-centered medical home" that makes care available 24/7. Such practices would be expected to be accountable for ensuring that their patients get all recommended care by using information technology and office systems to remind patients about preventive care and assisting them with obtaining needed specialty care.

These practices would be rewarded with an extra "medical home" fee paid by insurers and public programs, as well as extra bonuses for high performance in preventive care and chronic care management. Physicians would be encouraged to practice in more integrated delivery systems or virtual networks, working with other physicians, nurses, pharmacists, and other health professionals in a team approach to ensure coordination of care and shared accountability for health outcomes. This is a major change from our current isolated solo or small physician practice style of care, and will require not just funding but technical assistance and infrastructure support. To support provider groups as they reorganize—a challenging task even for large providers—the government should fund regional or state health information exchange networks, facilities that offer after-hours care to patients from different practices, case management help, and more.

Likewise, hospitals would be accountable not only for care during the hospital stay but follow-up care for 30 days following discharge, with incentives to improve transitions in care, reduce complications, and coordinate care as patients go back home or to rehabilitation facilities or other post-acute care. Hospitals would be rewarded for reducing complications and assisting patients with recovery, as well as ensuring that post-acute services are tailored to patients' needs. To carry out this role, hospitals would need to modernize their information systems and participate in health information exchange networks that ensure prompt information about hospital and emergency room care gets back to patients' primary care physicians.

Providers who accept accountability for patient health outcomes and prudent use of resources would be rewarded. Those who provide unnecessary, duplicative, or avoidable services would face revenue losses and would need to improve their processes of care and reposition their business operations.

Health expenditures would grow at 5.5 percent annually under the proposed policies, compared with 6.7 percent under current projections. A phased approach to payment reform will give providers time to prepare for the new payment methods and allow Medicare to develop appropriate rates, methods, and administrative structures that will support greater care coordination.

Employers

Along with households and governments, employers are expected to be part of the solution to gaps in coverage, variable quality, and high costs. All employers would be required to either provide health insurance that meets minimum standards to their employees or contribute 7 percent of worker earnings, up to $1.25 an hour, toward a coverage fund for employees.

While costs will initially increase for employers who do not currently shoulder some of the responsibility for providing coverage, businesses of all sizes stand to gain under the *Path* framework. Reforms will slow the rise in premiums with net cumulative employer savings of $231 billion over the period from 2010 to 2020.

Taxpayers

The net effect of the *Path* proposal could result in higher federal taxes and lower state and local taxes. The Commission did not recommend specific federal tax changes but noted revenues that could be generated, if necessary, through taxes on health insurance, health care, luxury goods, or incomes of $200,000 or more. Indeed, the *Path* proposal requires initial federal investments and sources of long-term financing to achieve maximum system savings. Taxes on harmful health products, including sugared soft drinks, calorie-dense foods, tobacco products, and alcoholic beverages are included; a portion of these revenues would be shared with state and local governments to launch obesity and smoking cessation initiatives.

As designed, federal government net outlays would increase by $593 billion over the 2010–2020 period and state and local government net outlays would decline by $1.034 trillion. Other design choices—such as increasing premiums paid by states to buy public coverage for the low-income elderly and disabled—could shift more of the savings to the federal government.

Deficit financing in the early years can be justified as part of an economic recovery program because expanded health insurance coverage will help stimulate the economy and create jobs, as well as contribute to better health and productivity. Making important investments in coverage, payment, and delivery reform now will reap savings in the long term. These actions, taken together, have the potential

to bend the curve of our unsustainable spending on health and generate systemwide savings of $3 trillion over 10 years.

Insurers

Perhaps the most challenging change is the proposed shift in the role of private insurers. Insurers would be required to provide coverage to all—healthy and sick alike—on the same terms. In addition, they would need to compete with a public plan that would be offered to all individuals and employers at a premium at least 20 percent lower than current premiums in the individual and small-business market.

To compete against a public plan with lower administrative costs and greater leverage over provider prices, private plans would need to bring added value, improved quality, and greater efficiency through tools available to them, such as selection of provider networks, utilization management, and benefit design. Some private insurers may adopt the public play innovations in payment—as they earlier adopted Medicare payment methods. This would provide even greater impetus to delivery system changes to improve quality and efficiency.

The public plan option is key to system savings. The *Path* report shows that $0.8 trillion would be saved by the coverage, payment, and system reforms without a public plan option, while $3 trillion would be saved with a public plan. The public plan is critical to lower administrative costs and ensure that savings from payment reform are passed on to employers and workers.

Under the *Path* proposal, an estimated 108 million Americans would retain private coverage, compared with the 178 million now covered by private plans. The net "loss" of private coverage is based on the assumption that private insurers will not alter their business operations to compete effectively with the public plan—an assumption that may well be proven wrong. Moreover, like Medicare, the public plan would contract with private insurers to administer claims for the 106 million people enrolled through the public plan, which would be a major expansion of the administered services business.

Integrated delivery systems that are able to provide higher quality care more efficiently—through their own hospitals and physician group practices—would experience a major expansion of enrollment, with over 50 million enrolled in such systems of care. Private insurers that are not linked to integrated delivery systems may try to emulate some of practices that lead organized care systems to achieve savings, such as funding nurses in physician practices to help patients with chronic conditions.

Health Industry

Any reform with the potential for $3 trillion in savings in a sector of the economy that is otherwise expected to spend $42 trillion represents a major shift to stakeholders. Pharmaceutical companies, for example, could expect to be paid lower prices for many of their medications as the government becomes a more active purchaser of prescription drugs. In addition, research on comparative effectiveness may find that certain new drugs do not offer added benefits, making public programs and insurers unlikely to pay more for the new drugs.

There are also business opportunities for the health industry. The uninsured will be able to afford needed medications. Currently only 40 percent of adults with hypertension, for example, have that condition controlled. New information systems and incentives for chronic care management could lead to a major increase in use of effective medications.

The almost universal adoption of information technology and health information exchange networks envisioned by the *Path* report—and given an important jumpstart by the economic stimulus legislation—will also provide business opportunities for the health industry. Accelerating the adoption and use of effective health information technology—with the capacity for decision support and information exchange across care sites—is required to bring about needed change in our care delivery system.

These investments will yield significant returns. The *Path* report estimates total system savings of $261 billion over 2010–2020 from increased use of health information

technology, and $634 billion in savings from comparative effectiveness research and its application to health insurance benefit, coverage, and payment decisions. Rather than denying patients effective care, utilizing value-based benefit design based on comparative effectiveness research will facilitate the use of safe, clinically proven care within the system and provide the information needed to improve value.

Health Security and Long-Term Fiscal Responsibility: A 2020 Vision

Although politically difficult, there is an urgent need to move in new directions. The comprehensive reforms proposed by the Commission will spark economic recovery, put the nation back on a path to fiscal responsibility, and ensure that all Americans are able to get the care they need and deserve. The cost of inaction is high. The nation needs national leadership and public–private sector collaboration to forge consensus to move in positive directions. With both an historic political opportunity and a clear path toward a high performance health system that works for all Americans, the time has come to take bold steps to ensure the health and economic security of this and future generations.

THE COMMONWEALTH FUND

RETHINKING THE MANAGEMENT OF FOUNDATION ENDOWMENTS

Executive Vice President and COO's Report
2009 Annual Report

RETHINKING THE MANAGEMENT OF FOUNDATION ENDOWMENTS

John E. Craig, Jr.
Executive Vice President and COO's Report
The Commonwealth Fund 2009 Annual Report

As the implications of the 2008–09 financial crisis for the world economy and markets have become clearer, many foundation executives and investment committees are reassessing their approach to endowment management. This essay reports on the effects of the recent turmoil on foundation endowments thus far, and offers lessons from the crisis and earlier ones that could help boards and investment committees responsible for foundation endowments avoid mistakes going forward. The essay concludes with an analysis of alternative models available to foundations for managing their endowments, highlighting the strengths and weaknesses of each and providing recommendations on preferred models.

A Bear Stock Market of Epic Proportions: The Impact on Private Foundations

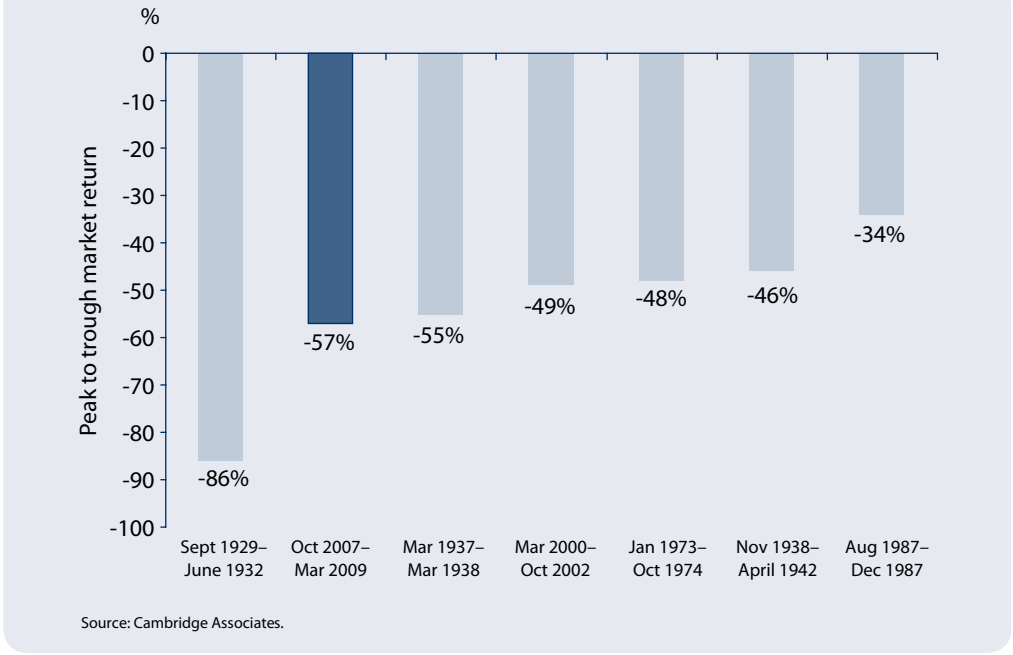
The bear market in stocks that began in October of 2007 and apparently bottomed in early March 2009 constituted the second most severe crash in stock prices on record—exceeded only by the September 1929 to June 1932 crash that ushered in the global Great Depression (Exhibit 1). Tellingly, the recent market decline exceeded by substantial margins any of the bear market declines that the current generation of endowment managers had experienced in their careers.

As a result of the market crash of 2008–09, the returns of most foundation endowments in the fiscal year ending on June 30, 2009, were severely negative: the average for 420 university and foundation endowments tracked by Cambridge Associates was –19.1 percent for the year (Exhibit 2). The crash has changed the financial landscape for foundations: most are now faced with three-, five-, and 10-year average annual returns well below the 5-percent-plus-inflation rate needed to ensure perpetuity.

Prior to the recent market crash, large foundation endowments with sophisticated investment strategies, patterned on those of major university endowments like Yale's, outperformed smaller endowments with more conservative investment strategies.[1] Because all asset classes except U.S. government bonds joined in the 2008–09 market rout, the risk-reducing benefits of diversification expected of the Yale endowment management model disappeared during the recent financial crisis—with the result that larger endowments uncharacteristically performed no better than smaller ones over the last year, and many did worse (Exhibit 3).

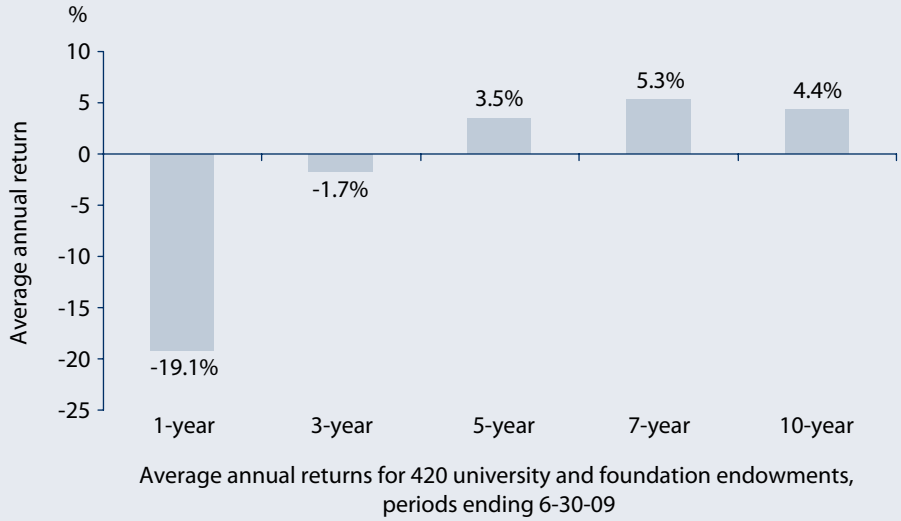
Photo: Robert C. Pozen, chair of MFS Investment Management, and William Y. Yun, executive vice president of Alternative Investments for Franklin Templeton Investments, are members of the Fund's Investment Committee, which Mr. Yun chairs. The Investment Committee, supported by the Fund's executive vice president-COO and Cambridge Associates consultants, oversees the management of the foundation's endowment, including determining the allocation among asset classes and selection of investment managers and closely monitoring investment performance.

Exhibit 1. The 2007–08 bear market in U.S. stocks was the second-most severe since 1929.



Source: Cambridge Associates.

Exhibit 2. In the July 1, 2008–June 30, 2009 fiscal year, university and foundation endowments suffered severely negative returns, pulling down their long-term average annual returns to levels insufficient to cover both inflation and the 5 percent payout required of foundations.



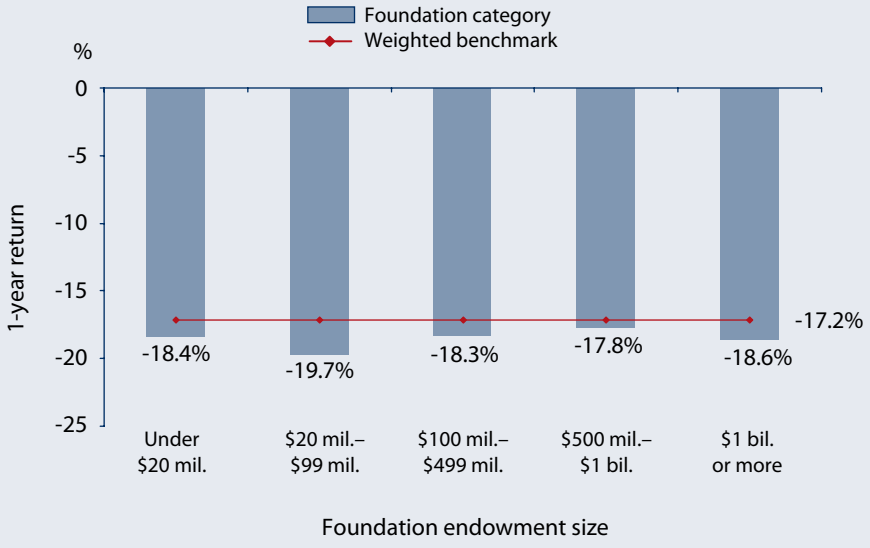
Source: Cambridge Associates.

Following the market crash, private foundation assets have likely declined by over 20 percent (Exhibit 4). March 2009 survey results reported by the Council on Foundations reveal that three-quarters of foundations experienced asset declines of 25 percent or more in 2008, and 47 percent reported a drop in endowment market value of 30 percent or more.[2] Since many foundations base their spending on the lagged three-year rolling average market value of their endowment, the immediate impact of the market crash on giving has been muted thus far. Even so, the Council on Foundations survey revealed that 48 percent of foundations reported plans to reduce the value of their total grantmaking by 10 percent or more in 2009. Sixty percent of responding foundations reported cutting their operating budgets in 2009, and 45 percent implemented salary freezes.

Will the 2009 Market Rally Last?

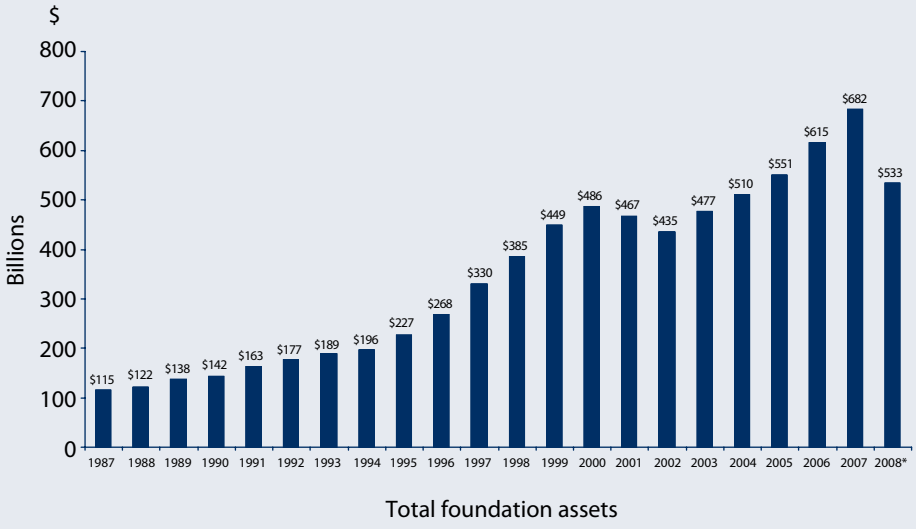
Along with other investors, foundation managers have been heartened by the global market rally that took off in early March 2009 (Exhibit 5). As impressive as the bounce-back returns have been thus far, however, they have not been sufficient to restore much of the wealth lost in the crash: the value of a dollar invested in U.S. stocks at the October 2007 peak was still worth only 70 cents (before inflation) on December 31, 2009. More worrisome, the history of stock market episodes following major financial system crises is marked by bear market rallies that raise hopes, dashed by subsequent corrections—as exemplified by the 2010 stock market correction that began on January 19 and pushed down U.S. stocks by 6.5 percent by February 12.[3] Further, there is widespread agreement that the rally to date has been concentrated in speculative, lower-quality stocks and based on the expansion of price/earnings ratios, rather than sustainable increases in corporate earnings.

Exhibit 3. In 2008–09, the endowments of very large foundations uncharacteristically did not outperform those of small foundations.



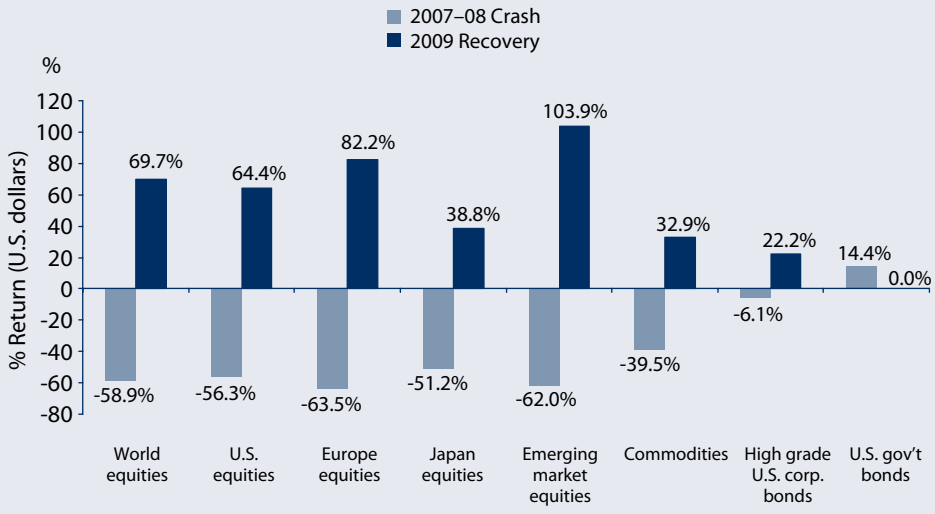
Returns are for the year ending June 30, 2009, for 22 foundations.
Source: Cambridge Associates.

Exhibit 4. As a result of the 2008–09 market crash, total private foundation assets have likely declined by more than 20 percent.



* Projected.
Source: Trend data, The Foundation Center; estimates, The Commonwealth Fund.

Exhibit 5. The post-crash recovery—will it last?



Source: Cambridge Associates.

Thus, venerable investors like Jeremy Grantham of the investment management firm GMO predict modest investment returns over the next seven years, especially in the United States: as of December 2009, the predicted average annual real return for large-capitalization U.S. stocks is about 1.3 percent, and that for small capitalization U.S. stocks, 0.5 percent (Exhibit 6). Grantham does hold out the possibility that these returns might be increased by skilled active managers, but the probability of achieving better returns depends crucially on whether the fault lines in the global financial system that caused the crash are being properly fixed, and on the prospects for the revival of economic activity.

Lessons from the Financial Crisis and Progress Toward Financial System Reform

Among the best of the numerous books analyzing the causes of the crisis in the financial markets is one written by Robert Pozen, chairman of MFS Investment Management and member of The Commonwealth Fund's board of directors and its investment committee. In *Too Big To Save?*, Pozen describes how the Federal Reserve set interest rates too low from 2001 through 2006, leading dollar investors across the world to search for higher yields from mortgage-backed securities than obtainable with U.S. Treasuries.[4] This global demand, given lax regulation of many mortgage lenders and excessive leverage allowed in Wall Street banks, drove housing prices to bubble heights. Pozen documents how the spread of new financial instruments such as collateralized debt obligations and credit default swaps introduced unappreciated major risks into the financial system, a problem compounded by the trading of such securities outside regulated exchanges and by the conflicted position of credit-rating agencies, whose compensation depended on favorable ratings for securities they were supposed to score objectively.

In his book, Pozen proposes a wide array of system reforms that he sees as key to putting the U.S. and global financial system on a firm footing for economic stability and growth. A number of these proposals are included in the financial system reform

Exhibit 6. Many analysts predict quite modest inflation-adjusted returns on equities over the next seven years, with the result that foundations will be challenged in meeting their objective of 5 percent annually.

Source: GMO LLC, January 2010 forecast. GMO notes that skilled active managers can improve on these predicted market returns.

legislation that is now being debated in Congress. In the debate, there is wide agreement on the need for the following reforms: a systemic risk monitor, higher capital requirements for financial institutions, more transparent and better organized markets for financial derivatives, as well as expansion of the federal government's resolution authority to cover insolvent nonbank financial firms. Passage of reform legislation, however, has been delayed by major points of disagreement, including the following: the scope of the Federal Reserve's authority, the proper agency for regulating consumer financial products, and the supervisory framework for mega-financial institutions in the system—how to insure their accountability and define a contained, low-cost role for government when they get into trouble.

Along with all Americans, foundation endowment managers have a great deal riding on the outcome of the ongoing financial system reform debate in Congress. The above-noted modest investment returns forecast for the next seven years are predicated on at least a modest economic recovery and average annual inflation of 2.5 percent. However, as documented by Carmen M. Reinhart and Kenneth S. Rogoff in a recently published landmark study of financial crises, the typical aftermath of a major bank-centered financial crisis involves a protracted period of falling GDP, often lasting two years or more.[5] In their review of eight centuries of financial crises, with special focus on those in this century, these scholars label the current turmoil as the "Second Great Contraction," ranking just below the one that produced the Great Depression. Thus, there is substantial risk that the nation may face slow growth and high unemployment for an extended period. This risk puts a premium on getting financial system reforms "right," and in place as soon as possible. As Rogoff notes, "If we don't re-regulate the banking system properly, we'll either get very slow growth from overregulation, or another financial crisis in just 10 to 15 years."[6]

Added to these risks are those posed by the state of U.S. finances—the level of government debt and persistent international balance of payments (current account) deficits that threaten long-term growth and stability. As Alice Rivlin, former vice chair of the Federal Reserve and founding director of the Congressional Budget Office, argues, "[T]he biggest economic challenge for 2010 is enacting credible future deficit reduction without derailing the fragile recovery."[7]

Avoiding Mistakes

In his book, Pozen lays out the mistakes made by many modelers responsible for the introduction of the complex financial instruments, such as mortgage-backed securities and credit default swaps, that played key roles in bringing the financial system to its knees in 2008.[8] Reinhart and Rogoff similarly identify recurring fallacies and lessons to be drawn from the history of financial crises. These two bodies of work can help foundations avoid mistakes in managing their endowments.

1. *Simple extrapolations of the past are dangerous.* Pozen cautions that "the differences between past and future trend lines can be as important as the similarities." For example, given the gravity of the current financial crisis, foundations should be careful about assuming that the historical average of market returns will prevail over the next several years.

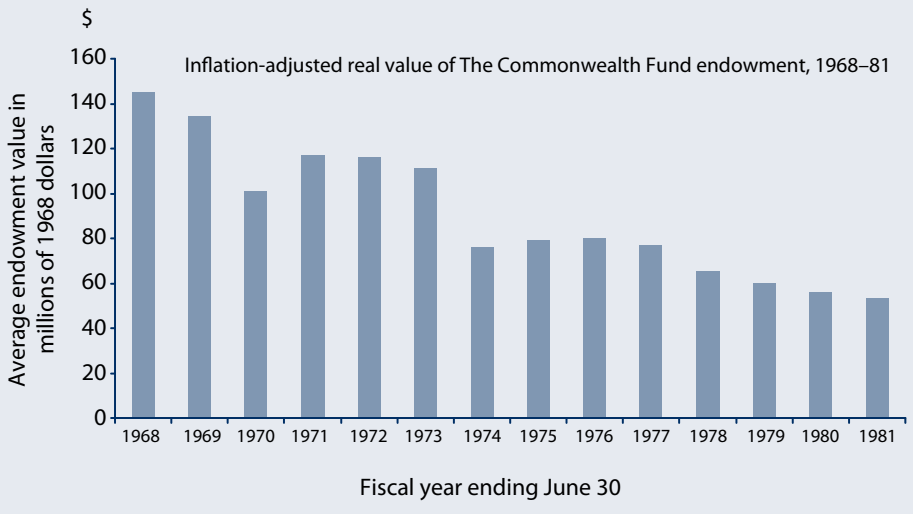
2. *Be patient in riding out financial bubbles.* As Pozen reminds us, investment bubbles can last for years, but economic fundamentals

ultimately win out. In safeguarding against bubbles, foundations should base their budgeting and investment strategies on what they perceive to be long-term realities. As Jeremy Grantham points out, this means in practice that in a financial bubble like that of 2003–08, perpetual foundations should allow their spending rate (spending as a percentage of endowment average market value) to fall—thereby setting aside "fat years" funds for use in the lean years that are inevitably to come.[9] More difficult, of course, is sticking to fundamentally sound investment strategies that produce below-benchmark returns in periods of market excess. As Pozen concludes, "the timing of the burst of any bubble is impossible to predict, so be very patient."

3. *"The frequency of extreme events is greater than people think,"* to quote Pozen again. Major global banking crises have occurred, on average, every 12 years since 1900, as Reinhart and Rogoff document, and every 11 years since 1945. For perpetual foundations, the occurrence within a 40-year period of two endowment-shaking crises like the financial crisis and oil shock-induced stagflation of the 1970s (when, as shown in Exhibit 7, it was not unusual for the inflation-adjusted market value of foundation endowments to decline by 60 percent) and the 2008 global financial disorder indicates that such crises are not "black swan" events. Foundation managers would be wise to heed Pozen's advice: pay more attention to low-probability events and hedge or insure against them if possible.

4. *Beware of the "This Time Is Different Syndrome."* As Reinhart and Rogoff describe, the thinking of the mid-2000s in the U.S. was "Everything is fine because of globalization, the technology boom, our superior financial system, our better understanding of monetary policy, and the phenomenon of securitized debt." In their research covering multiple centuries, these

Exhibit 7. The real value of a typical U.S. foundation's endowment declined by over 60 percent in the financial and stagflation crises of the late 1960s and 1970s.



Source: The Commonwealth Fund.

authors find similar thinking preceded virtually every financial crisis. Foundation managers should conclude that the siren call of "This Time Is Different" is a sure signal to lower the risk profile of the endowment.

5. *Be knowledgeable of the predictors of financial crisis.* Reinhart and Rogoff present a convincing body of evidence that markedly rising asset prices (particularly housing bubbles), slowing real economic activity, large current account deficits, and sustained debt build-ups (public or private) generally precede a financial crisis. Attention to such systemic risk measures can help foundations position their endowments to better weather financial crises.

6. *Understand how the origins of a financial crisis can greatly affect the depth and duration of its impact on economies and markets.* Reinhart and Rogoff's research informs us that bubbles are far more dangerous when they are fueled by debt, as was the case with the global housing bubble of the early-to-mid-2000s. Their study reveals that global financial crises arising from excess leverage are typically followed by very severe, multiyear slowdowns in economic activity accompanied by high unemployment. Just as such crises produce major bear markets in stocks, so they entail bear market rallies followed by resumed slumps. Endowment managers ignore this pattern at considerable risk.

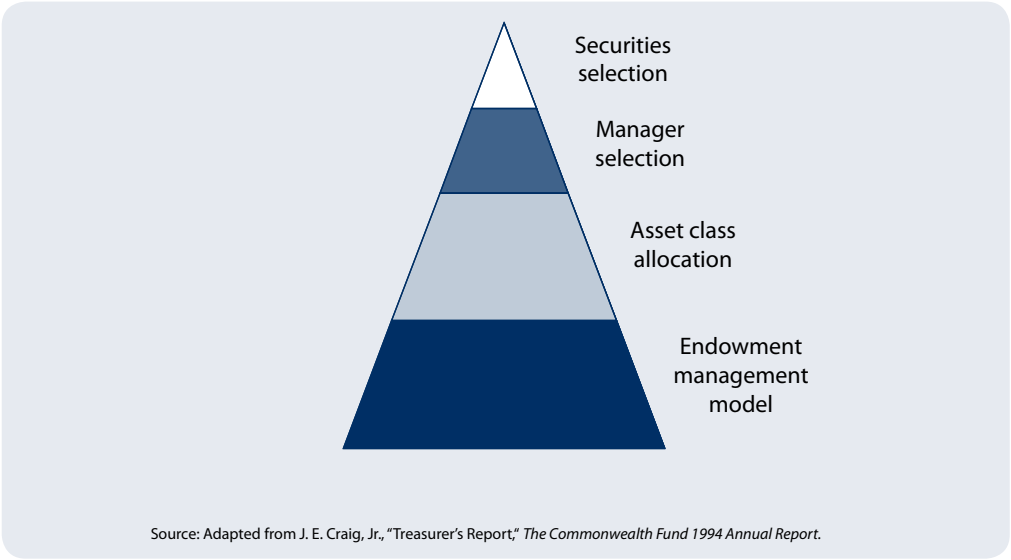
7. *Ignore liquidity risk at your peril.* With their deep endowment pockets and significant fixed-income holdings, foundations generally do not worry much about liquidity. But with increasing commitments to private equity and hedge fund partnerships, liquidity risk was already a real concern for many endowments before the recent financial crisis. The crisis demonstrated that this risk rises significantly as leverage increases within the financial system. Thus, foundations should keep necessary reserves on hand and take increasing care that they are cautiously invested as financial storms gather. As yields fall on short-term investments, foundations will be lured to higher-yielding alternative products, but the risks and liquidity profiles of such products require very close examination. In light of recent experience, a number of foundations have taken out lines of credit, and more should consider doing so.

8. *Be ready to question the experts.* Adapting Pozen's advice on how banks and investment firms should manage their expert modelers, a primary role of a foundation's investment committee is to understand the limitations of the foundation's financial staff, consultants, and investment managers. Committee members should ask questions that push the so-called experts to explore fully the risks involved in each strategy and the assumptions underlying any quantitative model.

Managing Foundation Endowments

The uncertainties arising from the 2008–09 market crash, the Second Great Contraction, the path of financial system reform, and the need to put the U.S. financial house in order mean that foundations face more challenges in managing their endowments than at any time since the interrelated monetary system crises of the late 1960s and the oil-shock-induced stagflation of the mid-1970s. In response to their

Exhibit 8. The management model of a foundation endowment ranks with asset class allocation as a key determinant of long-term performance.



Source: Adapted from J. E. Craig, Jr., "Treasurer's Report," *The Commonwealth Fund 1994 Annual Report.*

disappointing investment performance over the last several years, a number of foundations have already overhauled their approach to managing their endowment. The remainder of this essay will address options available to others that have misgivings about the suitability of their current model.

By the early 1980s, foundation managers, their investment consultants, and academic researchers had come to recognize that decisions regarding asset class allocation generally have greater impact on investment performance than does the choice of investment managers or individual securities—important as the latter two components of endowment management are. The widely used pyramid shown in Exhibit 8 reflects this consensus, indicating that the most important function of endowment fiduciaries is to determine the asset class allocation appropriate to current market circumstances, then to select investment managers best suited to implement the allocation decision—leaving the task of portfolio construction to full-time investment professionals.

While the literature on endowment management is replete with research and advice on asset class allocation, the manager selection process, and of course the selection of securities for different types of portfolios, it is remarkably silent on the makeup of the base of the endowment performance pyramid: the endowment management model specifying the role of investment committees, internal financial/investment staff, investment consultants, and external entities assigned with responsibility for making asset allocation and manager decisions.[10] Reflecting the bias of the research literature, foundation investment committees spend most of their time on investment strategy, when it is often the case that as much attention needs to be given to discussion of the ideal management model for making the most of the endowment.

The universe of private foundations is far more diverse than that of colleges and universities, comprising some 29,000 organizations in 2008 that range in size from tiny foundations with assets of less than $100,000 to the Bill and Melinda Gates Foundation, with assets of $38 billion. As shown in Exhibit 9, the distribution of foundation assets is heavily concentrated in some 300 organizations with

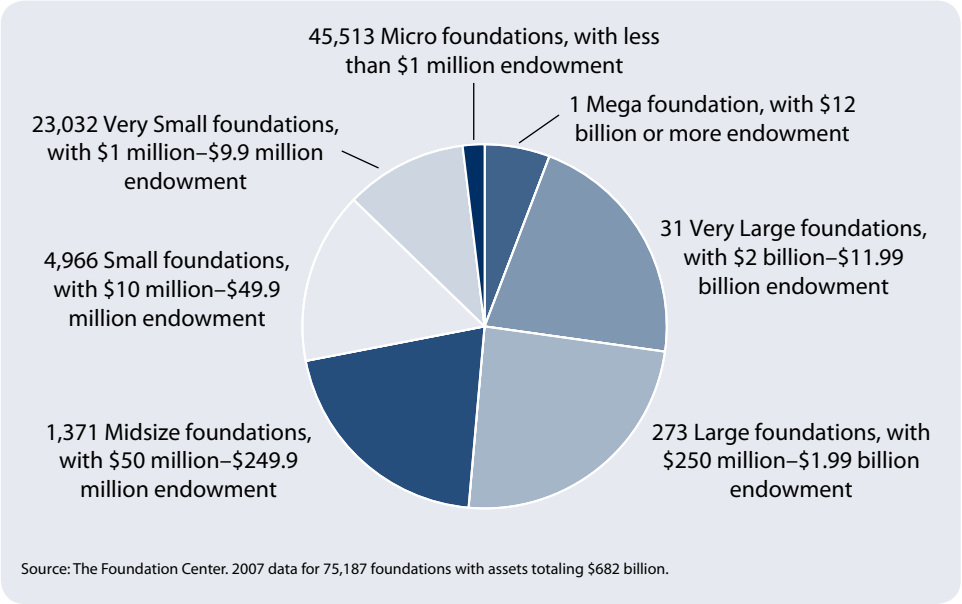
assets of $250 million or more, but even within this group, the size range is enormous. This diversity, as well as the uniqueness of each foundation's mission, culture, and history, makes it difficult to develop general lessons on how best to structure the management of an endowment. Even so, it is hoped that the following analysis will help fill an important gap affecting the performance of the foundation sector.

Foundation Endowment Management Models

The schematic in Exhibit 10 presents five basic models available to foundations for managing their endowments and the approximate level of delegation of authority by investment committees that goes with each. As the chart indicates, the delegation level for each model ranges substantially from foundation to foundation.

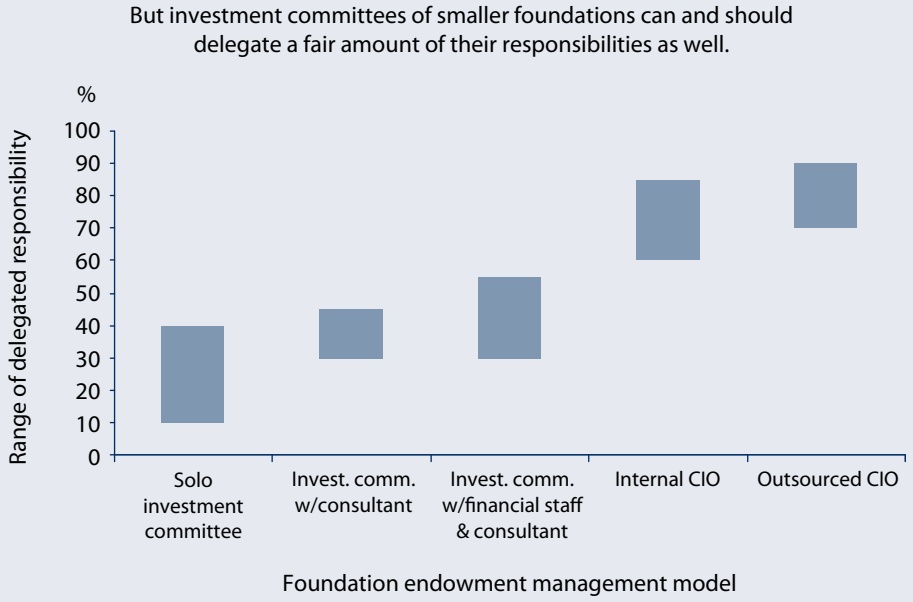
- **Solo investment committee model.** In this common approach, typically employed by very small foundations but also by many small and even midsize ones, the investment committee of the board has virtually all strategic and operational responsibility for the endowment—working with little or no internal staff or consultant support, although generally delegating portfolio management to a brokerage firm, mutual funds, or external investment managers (typically using commingled funds shared with other investors).
- **Investment committee-investment consultant model.** As foundation size and investment strategy complexity increase, many investment committees recognize the need for an investment consultant to help inform and guide their decisions, and sometimes to help implement them. The amount of responsibility

Exhibit 9. The distribution of foundation assets is heavily concentrated in some 300 foundations with assets of $250 million or more.



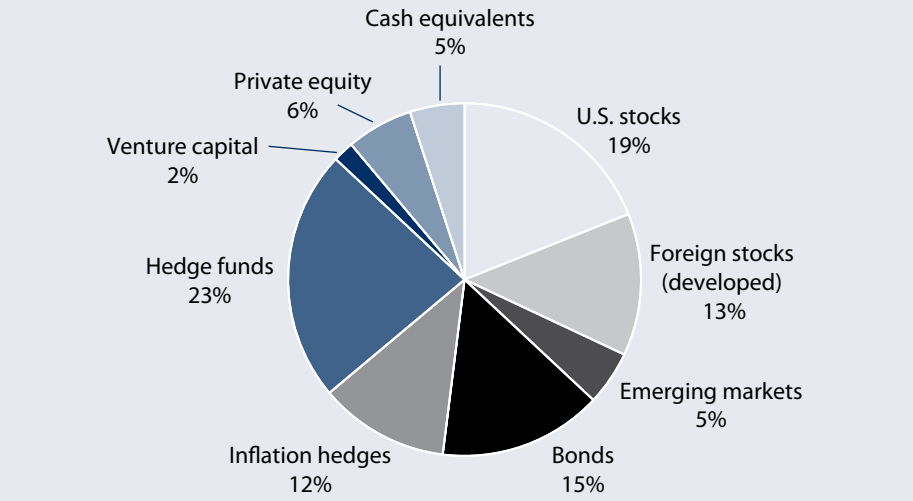
Source: The Foundation Center. 2007 data for 75,187 foundations with assets totaling $682 billion.

Exhibit 10. The larger the foundation, the more responsibility investment committees must delegate to consultants, internal chief investment officers, or outsourced CIOs.



Source: The Commonwealth Fund.

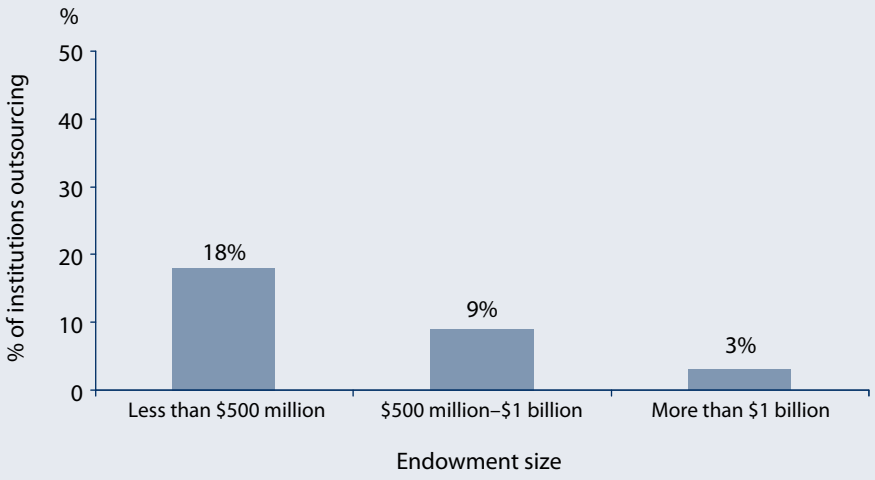
Exhibit 11. Over the last 25 years, larger private foundations have increasingly diversified their endowment portfolios, substantially increasing allocations to a variety of equity markets and reducing fixed income allocations.



Median % allocation of 85 endowments with median assets of $508 million, June 30, 2009

Source: Cambridge Associates.

Exhibit 12. Increasingly, nonprofits are fully outsourcing the management of their endowments.



Source: Casey Quirk & Associates, *The New Gatekeepers: Winning Business Models for Investments Outsourcing,* 2008.

delegated by the committee ranges significantly under this model, depending on the capacities and preferences of the committee and the ability and services offered by the consultant.

- **Investment committee-internal financial staff-investment consultant model.** Any foundation with assets of $250 million or more is likely to pursue the sophisticated diversified investment strategy shown in Exhibit 11. Under these circumstances, the day-to-day responsibilities of managing the endowment require qualified staff; moreover, barring an investment committee member with the time, inclination, and expertise for working closely with the consultant on strategic and operational issues like manager searches, a professional staff member is needed to ensure best use of the time and skills of the consultant and committee members. Thus, this model entails still higher de facto (if not formal) levels of responsibility delegation by the investment committee.
- **Internal CIO model.** Once a foundation reaches the $2 billion or so level in endowment assets, it becomes economic and feasible for it to hire a full-time, highly trained, experienced chief investment officer (CIO) and recruit a sizeable, dedicated professional investment team, compensated at the necessary competitive levels.[11] As described by Lawrence E. Kochard and Cathleen M. Rittereiser, a number of very large foundations including the Carnegie Corporation and William and Flora Hewlett Foundation use this model and have achieved considerable success.[12]
- **Outsourced-CIO (O-CIO) model.** Given the shortcomings of the solo investment committee, committee-consultant, and committee-financial staff-consultant models discussed below, the trend in recent years is for foundations with under $2 billion dollars in assets to fully outsource the management of their endowment to a firm that essentially offers a packaged set of services comparable to those that very large foundations obtain with an in-house CIO (Exhibit 12). The O-CIO firm—the best being the creation of a stellar former CIO

of a large university endowment or pension fund—assumes most of the responsibility for managing the endowment. While the amount of delegated authority varies from foundation to foundation, most investment committees using this model have an essentially advisory role and, beyond consultation on broad strategy, leave decisions on managers and tactical moves to the O-CIO. The spectrum of actual services offered by O-CIOs is wide, ranging from somewhat customized portfolios to one-size-fits-all proprietary portfolios.[13]

Small foundations are leading the trend toward the O-CIO model, but foundations in the $250 million to $2 billion range are also attracted to it—in large part because of their increased use of "alternative" investments like hedge funds, private equity, venture capital, real estate, and timberland, and the difficulties of identifying and gaining access to top-ranked managers of this type on their own. Contributing to the trend also is the disappointment of many midsize and large foundations with their existing investment committee- or consultant-driven management model in the recent financial crisis.[14] Foundations that have gone this route include the Rockefeller Brothers Fund, Colonial Williamsburg Foundation, John A. Hartford Foundation, Teagle Foundation, and Chichester DuPont Foundation.

It should be noted that the universe of firms offering the O-CIO model is diverse. While firms established by distinguished former CIOs of large university endowment or pension funds attract the most attention, many traditional investment consultants now offer such services (partly out of competitive necessity). Additionally, some traditional top-ranked balanced managers serve as O-CIOs to institutions like the Greenwall Foundation, although their products do not include alternative investments. Some offices of wealthy families also offer O-CIO services to selected clients other than the founding family, and, of course, banks have for years performed this function for foundations organized as trusts.

The strengths and weaknesses of each of these models are summarized in Exhibits 13a and 13b. The primary strength of the solo investment committee model is that it leaves, in theory, no doubt regarding where accountability for the management of the endowment lies. All too often, however, foundations employing this model shy away from the investments performance tracking that would help tell them how well their investment committee is functioning. Even when a record of below-market performance is clear, some boards are unwilling to hold the investment committee accountable for it. Small and even midsize foundations can find it difficult to attract board members with sufficient investment experience and expertise and the time or inclination to fully direct their skills to management of the endowment. Further, committee members are likely to develop a very limited set of investment managers from which to choose and may favor those they know—with attendant potential conflicts of interest. Indeed, board member conflicts of interest in the management of endowments arise all too frequently, and require firm attention by board and audit committee chairs.

Even with effective leadership, investment committees operating alone are sometimes challenged in reaching consensus and taking action, or fall into the trap of "group think." Under these circumstances, most small foundations using this model are best off employing only mutual funds, with a strong bias toward low-cost mutual fund indexes. Even so, the

Exhibit 13a. The *strengths* of foundation endowment management models.

Solo Investment Committee	Investment Committee-Consultant	Investment Committee-Consultant-Internal Staff	Internal CIO & Dedicated Investment Staff	Outsourced CIO
Committee exercises full responsibility for the endowment—no question of where accountability lies, provided performance is tracked and board holds committee accountable	Consultant brings: • Advice on asset allocation based on wide range of contacts and experience • Strong financial research base • Information on and access to a wide range of investment managers, including managers of nontraditional alternatives like hedge funds and venture capital • Independent voice, helping build consensus, avoid conflicts of interest	• More effective use of consultant, customization of services to foundation's particular needs • Better oversight of investment managers and endowment operations • More accountability • More safeguards regarding conflicts of interest • More integration of investment mission with program mission	• Full and measurable accountability for management of the endowment • High level of internal investment experience, expertise, and research capacity • Capacity to Identify and gain access to top-ranked managers, especially to nontraditional alternatives and rising-star managers • Undivided loyalty of CIO to the foundation • Potential contributions of CIO to foundation's program strategy (investment insights)	• Potential solution to "missing chief investment officer" problem for foundations with assets <$2 billion • Full and measurable accountability for management of the endowment • High level of investment experience and expertise • Pre-hiring investment track record • Capacity to Identify and gain access to top-ranked managers, especially to alternatives and rising-star managers • Proactive, rather than passive advice • Performance fees • Limited number of clients, low conflict-of-interest risk with O-CIO, if not also an investment consultant

weaknesses of the solo investment committee model are such that it is prone to being suboptimal.

Adding a qualified investment consultant to the investment committee model helps address many of these issues, but not all. The chief weakness of the investment-committee-with-consultant model is that responsibility for decision-making is muddied, and it is difficult for the board to hold either the committee or consultant accountable if things go wrong. While investment consultants bring research, experience, and contacts that are extremely valuable in building consensus, setting strategy, and hiring and firing managers, they can be more passive in providing advice than is desirable. Additionally, the quality of investment consulting firms can range widely, as can the value-adding capacity of any single consultant within even a strong firm.

There are other weaknesses as well. First, the performance record of investment consultants is reputational, not statistical, which presents a challenge in the hiring decision.[15] Second, consultants have many clients competing for their best ideas and

Exhibit 13b. The *weaknesses* of foundation endowment management models.

Solo Investment Committee	Investment Committee-Consultant	Investment Committee-Consultant-Internal Staff	Internal CIO & Dedicated Investment Staff	Outsourced CIO
• Challenges in recruiting members with sufficient investment experience and ability to commit required time and attention • Significant conflicts of interest risk • Potential board reluctance to hold committee accountable • Challenges of achieving consensus while avoiding "group think" • No investment research capacity • Limited capacity for identifying and gaining access to top-ranked managers—especially managers of alternatives and rising stars	• Accountability weakened by diffusion of responsibility and resulting difficulties regarding performance attribution • In hiring a consultant, reliance on references unsubstantiated by verifiable track records • Variable quality of individual consultants within a firm • Competition among many clients for consultant's attention and firm's best ideas and access to best managers—significant consultant conflicts of interest risk • Can be passive in offering advice—when conviction is needed • Unlikely to identify or propose innovative rising-star managers • Effective management of consultant can be an issue	• Weaknesses of Investment Committee-Consultant model mitigated, but not eliminated, and performance of model depends heavily on ability of internal financial staff to add value • Given multiple responsibilities and compensation issues, difficulties of attracting staff able to add value • Competing responsibilities of internal financial staff, limiting their ability to add value to investment process	• Economic only for foundations with $2 billion or more endowment • Challenges of recruiting and retaining star CIO, compensation issues • Potential oversight issues • Potential culture conflicts between program and investments staffs	• Key person risk • Possible limits on customization of strategy/services to individual foundation needs • Significant conflicts of interest risk for O-CIO, if also an investment consultant • Adequacy of oversight by foundation investment committee • Limited number of truly able O-CIO firms available, and limitations on their client capacity • Concern that outsourcers will, over time, add clients beyond optimal level

access to the best firms in their pools of investment managers. Third, consultants are unlikely to recommend partially tested, rising-star managers or cutting-edge products—although achieving above-market performance virtually depends on beating other investors to new investment approaches. Finally, as with any consultant, investment consultants provide their best work through a strong working relationship with, and guidance from the client; yet many investment committee chairs lack the time required to provide such guidance.[16]

Foundations with assets of roughly $150 million or more find it economic to seek to enrich the potential of the investment committee-consultant model by assigning a qualified foundation staff member responsibility for managing the consultant and orchestrating investment committee meetings. With the right experience, training, and judgment, an internal chief financial officer can greatly strengthen the committee's ability to make the most of the investment consultant's skills, ward against any problematic conflicts of interest, ensure firmer daily oversight of endowment operations and their integration with the foundation's operating needs, and bring helpful investment insights to program strategy and grantmaking. Even so, while accountability can be enhanced by the addition of qualified staff, it remains an issue. More seriously, staff in these roles typically have multiple and substantial other responsibilities within the foundation, and may lack either or both the time or expertise to produce all the benefits of this approach. Foundations employing this model, moreover, often face a major challenge in identifying and adequately compensating a staff person able to meet the many demands of the assigned role.

The vitally missing piece in the first three models is a chief investment officer—a role which should arguably be assigned, at least de facto, to someone in any organization totally dependent on an endowment for income. Well executed, the internal CIO model addresses most of the shortcomings of the first three models. Besides being unaffordable for all but about 30 of the largest private foundations, however, the chief weaknesses of this approach are the challenges of recruiting and retaining a highly qualified CIO, particularly given the compensation such individuals draw in other settings.[17] While CIOs can add value to the foundation's programs, culture clashes between programmatic and investment staffs do arise, and the foundation needs to take care that the values of the foundation and the CIO are fully aligned, and that the strong personality that is typically a CIO trait fits into the foundation's management structure.

Like the internal CIO model, the outsourced-CIO model also addresses most of the weaknesses of alternative management approaches. The constraint here is the number of highly qualified individuals and firms to which such responsibility can be safely delegated. As predicted in a study by Casey Quirk and Associates, many former large university or pension fund heads will set themselves up as O-CIOs in the coming years—but not all will be true investment stars.[18] The ability of the largest group of entrants into this business—established investment consultants—to deliver high-quality O-CIO services stands a substantial risk of being compromised by their responsibilities to existing consulting clients and their questionable ability to attract truly outstanding investment professionals. There are also concerns that while existing O-CIO firms restrict the number of clients to the small number needed to ensure above-market returns, they will be pressured over time to grow the firm beyond an asset level that is optimal for clients.

Other issues with O-CIO firms include the extent to which they can customize services to the needs of individual foundations and the extent to which an investment committee feels it has adequate oversight of the O-CIO. Among the best of existing O-CIOs, any shortcomings on these issues are more than offset by their skills and thus performance. The remaining risk, "key person," is thus the primary one—the viability and strength of the firm should it lose its star CIO. This risk is real, as most outstanding O-CIO firms are small. At the same time, given the newness of this model, few such firms are likely to face a transition in leadership for the foreseeable future.

To sum up, the three existing endowment management models used by most foundations—solo investment committee, investment committee with consultant, and investment committee with consultant and limited financial staff—all have serious limitations that make it unlikely that they will produce, over the long term, returns greater than those of the market and present considerable risk of generating below-market returns. Yet very few foundations are likely to be able to pursue the two alternative models, because of the economic infeasibility of the CIO approach for most foundations and the limited availability and capacity constraints of truly outstanding firms able to serve as outsourced CIOs.

Fortunately, The Investment Fund for Foundations (TIFF) was established in 1991 to help overcome many of the shortcomings of the principal endowment management models available to most foundations. Patterned after the CommonFund, which was established for educational institutions in 1971, TIFF enables foundation and other nonprofit investment committees to get out of the business of identifying and selecting managers by offering pooled funds invested by teams of multiple managers hired by the TIFF board.[19] The range of products offered by TIFF is wide—from mutual funds for conventional U.S. equities, international equities, and bonds, to hedge fund, private equity, and natural-resources investment pools. In addition, TIFF's Multi-Asset Fund provides foundations an efficient vehicle for fully outsourcing the management of the endowment. While not offering investment consulting services, TIFF staff does help educate foundation trustees on asset class allocation and other investment issues. Operating as a nonprofit cooperative and with a highly trained and experienced staff and board, including some of the most respected endowment and pension fund CIOs in the country, TIFF avoids many of the pitfalls, articulated so well by Yale University's David Swensen, of management approaches dominated by for-profit fund-of-fund managers, consultants, and inadequately equipped investment committees.[20]

Given the strengths and weaknesses of this array of approaches for managing foundation endowments, the following recommendations seem appropriate:

- Foundations with assets of $2 billion or more will generally be best off by hiring a highly qualified chief investment officer, supported by a sizeable dedicated internal investments staff.
- For other foundations, particularly those with assets in the range of $500 million to under $2 billion or so, identifying an outstanding outsourced-CIO firm is the preferable approach. Foundations with assets of $20 million–$50 million are also prime candidates for this approach, as their size is well suited for rounding out an O-CIO's portfolio of clients. The limited supply and capacity of outstanding O-CIO managers, however, means that relatively few foundations will actually be able to successfully execute this model.

- Great care, obviously, must be taken in selecting an O-CIO, with respect not only to their qualifications but also to potential conflicts of interest involving board members. Given the amount of delegation of board responsibilities involved, any conflicts of interest should be avoided, and most committees would benefit from using a consultant to professionalize the search for, and screening of, candidates. The obvious conflicts of interest that investment consultants face in simultaneously serving traditional and O-CIO clients lead to the conclusion that, with rare exceptions, the O-CIO responsibility should not be delegated to consultants. As with any investment manager, the performance of an O-CIO should be judged over a market cycle.
- Foundations with assets under $2 billion that are unable or disinclined to outsource should make the most of the investment committee-consultant-internal financial staff model by taking maximum advantage of the products offered by TIFF or other nonprofit fund-of-fund managers.
- Foundations with less than $100 million in assets may not be able to retain internal staff capable of adding value to the investment committee's work, but only the smallest foundations (assets of $20 million or less) can justify, for economic reasons, going without the benefits of an investment consultant. Smaller foundations that choose not to use an investment consultant should make all the more use of TIFF by taking full advantage of the investment educational services and advice that it offers.

Making the Most of Investment Consultants

Since most foundation investment committees should supplement their skills with those of an investment consultant, it is well to consider guidelines for selecting and using such consultants effectively. As Robert Marchesi has written, there are more than 100 investment consulting firms in the United States, and the scope and quality of their services vary enormously.[21]

In selecting a consultant, the first task of an investment committee is to define the level of services it needs to address gaps in the committee's capacities. Most committees need a significant number of services from their consultant, including investment research, investment strategy, manager searches and selection, and regular consultation with the committee and internal staff. If the foundation lacks internally or through its securities custodian the ability to measure and report investment performance, this service should also be sought from the consultant.

Exhibits 14a and 14b summarize desirable and undesirable traits to look for when selecting an investment consultant for a foundation endowment. A strong weight should be placed on the consultant team's investment experience and training, but equally important is the firm's business structure, with particular attention to conflicts of interest. The investment committee should probe to see if the consultant is honest about its own strengths and weaknesses, and whether it is willing to recommend competitors (e.g., TIFF or low-cost index funds) when they offer superior products. As the Madoff scandal of 2008 demonstrates, the investment consultant should be able to explain the investment strategy of any firm in its stable of managers, and should demonstrate deep knowledge of each firm's business. Regardless of recommendations from the consultant's existing clients, a foundation investment

Exhibit 14a. Selecting an endowment investments consultant—essential traits.

- Firm is independent, with no ownership conflicts.
- Firm displays high level of integrity and appreciation of conflicts of interest that arise regularly in investing.
- Firm recognizes its limitations—does not, for example, offer O-CIO services that it is poorly equipped to provide.
- The lead consultant offered by the firm is skilled and experienced, and interacts well with investment committee members and staff.
- The lead consultant is backed up by a deep team of researchers and investment professionals with a wide range of contacts in the investment manager business.
- Lead consultant advises with conviction, strengthening committee's decision-making process.
- Firm is transparent on the investment managers with which it works and is able to fully document and explain any recommended manager's investment strategy, performance, and risks.
- Firm has a range of investment manager types in its stable—with respect to size, investment style, age, risk/reward profile—and has a record of identifying promising new managers and recommending them for clients' consideration when appropriate.
- If the foundation is large enough to invest in the "alternatives" areas, the consulting firm has demonstrated capacity to identify top-ranked managers of this type and gain access to them for its clients.
- Firm is willing to recommend TIFF and other nonprofit pooled fund products, as well as low-cost index funds when these can serve the client best.
- The foundation will be an important client to the consulting firm, ranking high in its pecking order for recommending clients to leading investment managers.
- Firm and proffered lead consultant produce multiple strong client references.
- Firm offers a competitive fee structure, with no imbedded conflicts of interest.

Exhibit 14b. Selecting an endowment investments consultant—traits to be avoided.

- Firm owned by a larger business selling investment products posing conflicts of interest.
- Firm has a record of involvement in conflicts of interest, questionable practices.
- Firm is essentially a "feeder" for large investment managers, mainly serving to steer clients to established managers.
- Firm offers services—e.g., O-CIO, that it is ill-equipped to provide.
- Firm's team has questionable investment training and experience.
- Concern that the proffered lead consultant may not be their best, or that interactions with the lead consultant could prove problematic.
- Lead consultant is passive in giving advice, weakening committee decision-making process.
- Firm is secretive regarding its investment manager pool and is unable to document and explain some managers' strategy, performance, and risks.
- Firm is so small that it is likely to offer the same set of investment managers to all clients, and be limited in its ability to identify and recruit promising new managers to its stable.
- Firm is unable to identify and gain access to leading managers in important areas in which the foundation wishes to invest.
- Firm is unwilling to recommend TIFF or other nonprofit pooled funds or low-cost index funds when appropriate, instead offering up inferior products for its own business reasons.
- The foundation will be a marginal client for the firm, unlikely to receive "preferred customer" attention in opening doors to skilled investment managers.
- Client references on the firm or proposed lead consultant are limited and inconclusive.
- Firm has noncompetitive fee structure or fee arrangements posing potential conflicts of interest.

committee and staff should focus on the ability of the lead consultant to meet the particular needs of the foundation and on the personal chemistry that emerges in the screening process.

Consultants, in general, are no better than the individual directing the use of their services, and this rule applies equally in the endowment management business. Thus, investment committees should lay out clearly in the foundation's investment policy statement the division of responsibilities among committee members, any internal staff, and the consultant, and assign a specific committee member or staff person with responsibility for guiding the consultant's work. The foundation person charged with this responsibility should have available the time needed to advise and direct the consultant effectively. To play this role well, the committee member (usually the chair) or staff member should be well informed about the foundation's overall financial picture and program objectives and skilled in using the consultant's services to advance effective committee decision-making.

Just as most foundations judge the performance of their investment managers over a market cycle, so should the performance of the investment consultant be reviewed periodically—about every five years. Such reviews are best carried out in the context of considering a small number of alternative consultant firms, as the strengths and weaknesses of the existing consultant are more clearly illuminated by comparisons with other firms.

Conclusion

Every crisis presents opportunity, and many foundations should at this time take a hard look at their basic structure for managing their endowment. In doing so, they should aim for accountability on the part of each major player sharing responsibility for the endowment, and for a management model likely to make the most of their resources while protecting against major risks. In a period of great uncertainty, foundations should give heightened attention to the composition of their investment committees and to the skills and time priorities of members. They should also reassess the extent to which their investment committee is adequately staffed to do its job, and whether external resources need to be tapped to ensure strong endowment management.

NOTES

[1] John E. Craig, Jr., "New Financial Realities: The Response of Private Foundations," *The Commonwealth Fund 2008 Annual Report* (New York: The Commonwealth Fund, March 2009).

[2] Council on Foundations, *Foundations Respond to the Needs of Families Even as Their Assets Have Declined,* May 6, 2009, www.cof.org/economicdownturn.

[3] Cambridge Associates, "Living on Borrowed Time? Dissecting the Current Equity Market Rally," Sept. 2009.

[4] Robert Pozen, *Too Big To Save? How to Fix the Financial System* (Hoboken, N.J.: John Wiley & Sons, Inc., 2010).

[5] Carmen M. Reinhart and Kenneth S. Rogoff, *This Time Is Different: Eight Centuries of Financial Folly* (Princeton, N.J.: Princeton University Press, 2009). Ms. Reinhart is professor of economics at the University of Maryland; Mr. Rogoff is the Thomas D. Cabot Professor of Public Policy and professor of economics at Harvard University.

[6] "After the Bailouts, Washington's the Boss," *Wall Street Journal*, Dec. 28, 2009.

[7] Alice M. Rivlin, "U.S. Debt Scolds Can't Be Ignored Much Longer," Bloomberg, Jan. 6, 2010.

[8] Pozen, *Too Big To Save?* 2010, pp. 82–94.

[9] Jeremy Grantham, "Just Desserts and Markets Being Silly Again," *GMO Quarterly Letter,* Oct. 2009. Although the Internal Revenue Service requires private foundations to distribute 5 percent of their endowments annually, in practice the payout rules enable foundations to meet the requirement over a period of years. This makes Grantham's advice practicable, and it is heeded implicitly by the many foundations that base their annual payout on a lagging three-year (or longer) average endowment market value.

[10] The definitive book on endowment management, David F. Swensen's *Pioneering Portfolio Management* (Free Press, 2009), for example, focuses on the circumstances of very large universities, which are able to afford and recruit internal professional investment staffs that assume responsibility for management of the endowment.

[11] Dennis R. Hammond, "Choosing the Best Investment Management Structure: Use of Consultants to Drive the Investment Process," Hammond Associates, Foundation Financial Officers Group meeting, Sept. 27, 2007.

[12] Lawrence E. Kochard and Cathleen M. Rittereiser, *Foundation and Endowment Investing* (Hoboken, N.J.: John Wiley & Sons, Inc., 2008).

[13] Casey Quirk & Associates, *The New Gatekeepers: Winning Business Models for Investments Outsourcing*, Dec. 2008. Lawrence Kochard and Cathleen Rittereiser describe the business models and investment strategies of such leading O-CIO firms as Investure and Morgan Creek Capital in Kochard and Rittereiser, *Foundation and Endowment Investing*.

[14] Cambridge Associates: "'Fiduciary Fatigue' CIO Outsourcing: Leaner Times Increase Demand, and Raise New Questions," 2009.

[15] Investment consultants should be able to produce the "blinded" investment performance records of their clients, but only in the limited number of cases where consultant firms have virtually total responsibility for the endowment can they attribute the extent to which the record reflects their decisions, as opposed to those of the investment committee or internal staff.

[16] Many foundation investment committees reject the idea of retaining a consultant because of the cost. In fact, the fees of most such firms, measured as a percentage of the market value of the endowment, are quite reasonable. Reflecting the economies of scale enjoyed by larger foundations, standard investment consultant fees range from approximately 60 basis points on the endowment market value for a foundation with a $20 million endowment, to 8 basis points for one with a $250 million endowment, to 6 basis points for a foundation with a $500 million endowment. Given that most foundations have only one source of income, and are typically otherwise dependent on volunteer trustee services for overseeing the endowment, they are well advised to spend at least these levels of resources to enhance their endowment management capacities.

[17] A novel approach to solving this problem is provided by three Indianapolis foundations that recently jointly together to hire an experienced CIO to manage the three endowments. The foundations have combined assets of around $1 billion, and they share the costs of the CIO office.

[18] Casey Quirk & Associates, *The New Gatekeepers,* 2008.

[19] Over the years, the CommonFund and TIFF have opened their doors to other nonprofits, and both now serve both educational organizations and foundations.

[20] Swensen, *Pioneering Portfolio Management*, 2009, pp. 309–12. The author of this essay is a member of the board of the TIFF Education Foundation, but not of TIFF Advisory Services or TIFF Investments Program, the investments arms of the TIFF organization.

[21] Robert F. Marchesi, DeMarche Associates, www.demarche.com.

THE COMMONWEALTH FUND

2009 Annual Report

The Fund's Mission, Goals, and Strategy

Commonwealth Fund chair James R. Tallon, Jr., president of the United Hospital Fund, and Board member Cristine Russell, reporter. *Photo by Martin Dixon.*

The Fund's Mission, Goals, and Strategy

The mission of The Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

GOALS

The Board of Directors has identified the following goals to be pursued by the Fund over the next several years:

Move the United States toward a high-performing health care system that achieves better access, improved quality, and greater efficiency, and focuses particularly on the most vulnerable due to income, inadequate insurance, minority status, health, or age.

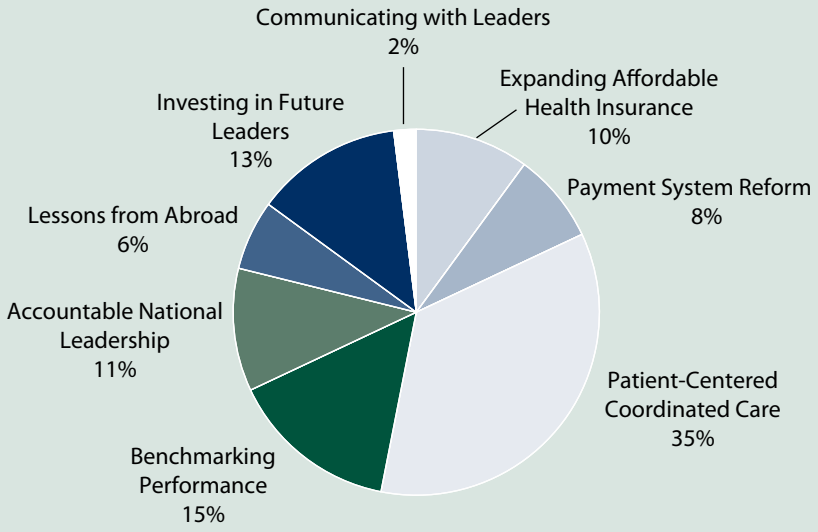
- This overarching goal is being advanced through the Fund's Commission on a High Performance Health System, which is charged with setting and tracking national and state performance targets, developing policy options, and disseminating innovative practice changes that would improve the functioning of the U.S. health system. The Fund's grantmaking programs support and enhance the Commission's work.

Achieve an efficiently run health insurance system that makes available to all Americans comprehensive, affordable coverage.

In support of this vision, the Program on Affordable Health Insurance seeks to:

- provide timely analysis of changes in private and public insurance coverage for people under age 65, as well as the impact on the number of people covered and the quality of coverage;
- document the consequences of being uninsured and underinsured on people's health, finances, and productivity; and
- analyze and develop policy options to expand, stabilize, and improve the affordability of health insurance coverage, as well as increase its administrative efficiency.

Exhibit 1. The Fund's grants programs, in concert, pursue eight strategies for promoting a high performance health care system.



Allocation of grants from July 2005 through November 2009

Help public and private insurers, especially Medicare, be an innovative leader in coverage, quality, and value improvements.

To this end, the Program on Payment System Reform supports analysis and the development of policy options to curb spending growth and improve the way health care is provided. Areas of interest include:

- changing existing payment systems to improve the alignment of incentives to promote better quality and efficiency and to provide a base for more comprehensive payment reform;
- modeling and analyzing the potential impact of alternative options for payment reform in Medicare and throughout the health system;
- reforming provider payment to encourage the development of new models of health care delivery that provide better and more coordinated care; and
- using comparative effectiveness research to support better decision-making by providers, payers, and patients.

Improve the quality and promote the efficiency of health care services.

The Program on Quality Improvement and Efficiency is based on the premise that improvements are most likely to occur when the need for change is understood, measured, and publicly recognized; when providers have the capacity to initiate and sustain change; and when appropriate incentives are in place. The program supports projects that:

- promote the development and widespread adoption of measures of health care quality and efficiency;
- assess and enhance the capacity of health care organizations to provide better care more efficiently; and
- promote the development and adoption of payment and incentive models that encourage health care providers to improve quality and efficiency.

Spur the redesign of primary care practices and health care systems around the needs of the patient.

The goal of the Fund's Program on Patient-Centered Coordinated Care is to improve the quality of primary care by making it more patient- and family-centered. The initiative supports projects that:

- promote the collection of patient-centered information to facilitate public reporting, quality improvement, and payment reform;
- disseminate effective practices, models, and tools to improve patient- and family-centered care in primary care practices; and
- improve policy to encourage patient- and family-centered care in medical homes—primary care practices or health centers that provide patients with enhanced access to their clinicians, coordinate all care, and engage in continuous quality improvement.

Improve state health systems' performance to ensure that residents have access to affordable, high-quality health care.

The Program on State Health Policy program does this by:

- working with state-initiated private–public partnerships to develop the policies and infrastructure necessary to improve the quality of care and ensure greater accountability for patient outcomes; and
- disseminating lessons from the experience of states as they work toward comprehensive health care reform.

Transform the nation's nursing homes and other long-term care facilities into resident-centered organizations that are good places to live and good places to work.

The Picker/Commonwealth Program on Quality of Care for Frail Elders aims to:

- identify, test, and spread effective, person-centered practices, models, and tools;
- help nursing homes become high performance organizations; and
- track and respond to policy issues and health care system trends that affect long-term care.

Promote international exchange on health care policy and practice.

To advance cross-national learning, the Fund's International Program in Health Policy and Innovation aims to:

- build an international network of health care researchers devoted to policy;
- encourage comparative research and collaboration among industrialized nations; and
- spark creative thinking about health policy through international exchanges.

Foster the growth of the knowledge, leadership, and capacity needed to address the health care needs of a growing minority population.

This goal is advanced by the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy—aimed at training leaders. Additionally, all of the Fund's programs look for opportunities to identify policies and practices that will promote equitable health outcomes for minority, low-income, and other underserved populations, eliminate existing disparities in care, and enhance the performance of safety-net systems of care.

Augment the Fund's leadership in effectively and broadly disseminating credible, authoritative information about policy options and innovative approaches to moving the United States toward a high-performing health care system.

This goal is pursued through the Fund's Communications department, which harvests the results of

the foundation's grants and intramural research and uses state-of-the-art online and electronic publishing tools to reach influential audiences.

STRATEGIES

The Commonwealth Fund employs eight strategies for advancing its goals, with most cutting across programs:

- expanding affordable health insurance, the recent allocation of extramural grant funds for which is 10 percent;
- advancing payment system reforms that embody financial incentives to enhance value and achieve savings (8%);
- promoting the delivery of health care that is patient-centered, high-quality, accessible, and coordinated (36%);
- benchmarking health care delivery to enable improvement in performance (16%);
- ensuring accountable national leadership and public–private collaboration (6%);
- bringing the international experience to bear on U.S. health system reform (11%);
- investing in future leaders (13%); and
- communicating results to influential audiences (2%).

In all its work, the Fund seeks particularly to target issues that affect vulnerable populations. It also aims to achieve a balance between information-generating and action-oriented activities, and between public- and private-sector work. Also guiding the foundation's grantmaking strategy are: keeping the doors open to new talent; working in partnership with other funders; being receptive to new ideas; undertaking appropriate risks; and contributing to the resolution of health care problems in the Fund's home base, New York City, while simultaneously pursuing a national and international agenda.

Exhibit 2. The Fund's work seeks particularly to address the problems vulnerable populations face in accessing health care that is affordable, of high quality, and efficiently delivered.

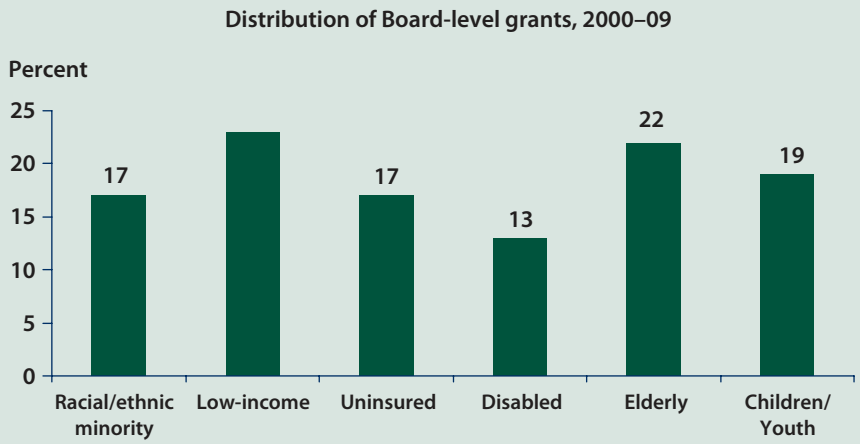


Exhibit 3. In structuring programs and selecting grants, the Fund seeks to achieve an appropriate balance within each program between research and action-oriented work, and between public and private sector work.

Distribution of Board-level grants, 2000–09

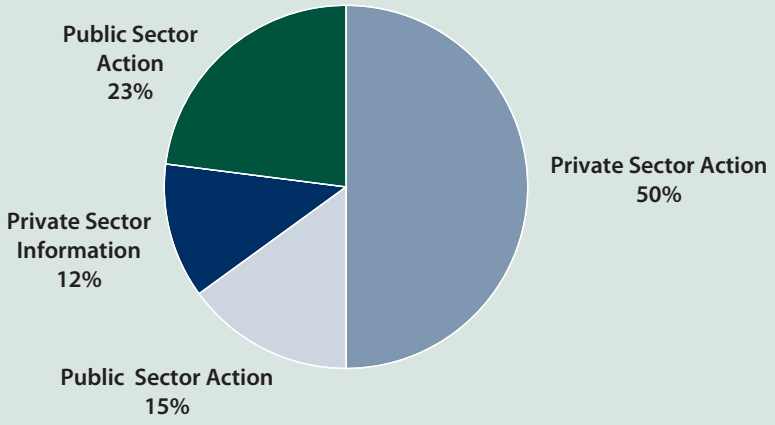
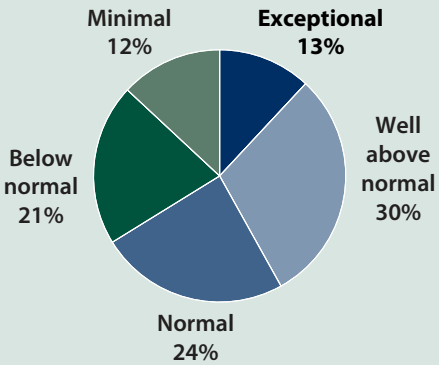
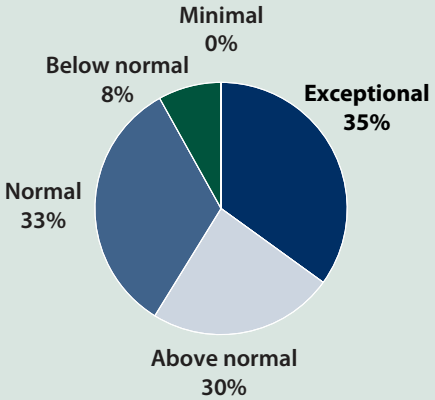


Exhibit 4. An important role of the Fund's value-adding staff is to identify project risks and work closely with project directors in managing them to achieve success.

Risk of Board-level grants, 2000–09



Staff effort applied to Board-level grants, 2000–09

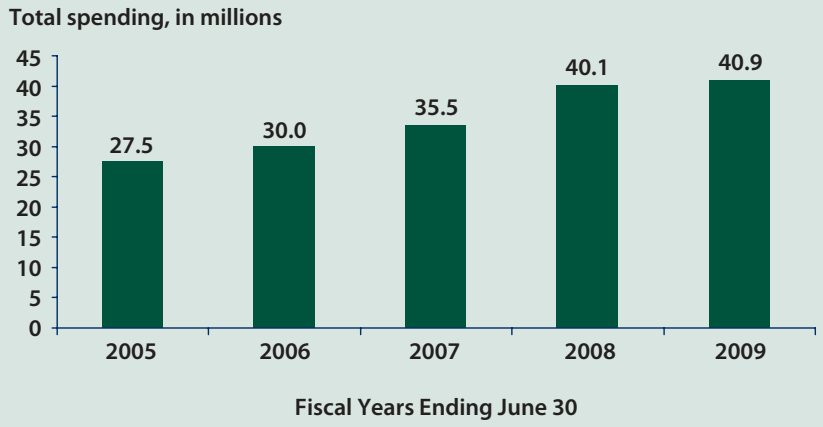


RESOURCE MANAGEMENT

Owing to the effects of the 2008–09 financial crisis and the resulting bear market on the Fund's endowment, the Board of Directors found it necessary to reduce the foundation's annual budget by 15 percent in 2009–10, lowering it from $40.9 million to $37.8 million. Additional reductions are expected to be necessary over the next several years to bring the overall annual spending rate down to the long-term target of 5.4 percent of the endowment—a rate consistent with the foundation's objective of perpetuity. In 2008–09, management began a series of carefully planned, strategic spending reductions, which should enable the foundation to continue to be a strong force for health system reform, despite a lower spending level.

Reflecting The Commonwealth Fund's value-added approach to grantmaking, approximately 32 percent of the foundation's total budget is devoted to intramural units engaged in research and program development, collaborations with grantees, and dissemination of program results. This allocation includes approximately $2.4 million annually to communicate the results of Fund-sponsored work and funds to operate programs directly managed by the foundation. The portion of the foundation's total budget devoted to administration is 5 percent.

Exhibit 5. Over the five years ending June 30, 2009, the Fund expended a total of $172 million to promote a high performance health care system.



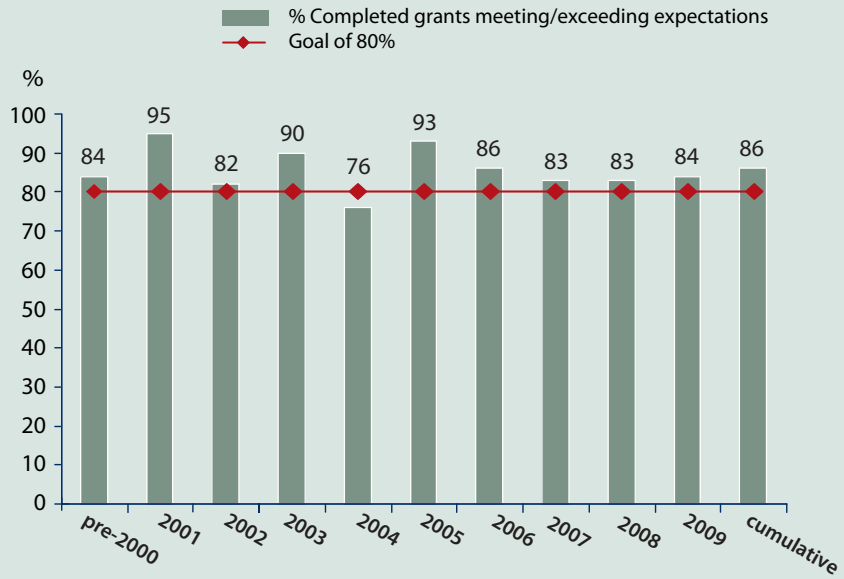
FOUNDATION PERFORMANCE

The Commonwealth Fund is one of only a handful of foundations using an annual performance scorecard to provide their boards with a means of achieving a comprehensive assessment of the institution's overall performance and spotting weaknesses that need attention. The scorecard has 23 metrics, covering four dimensions: financial performance, audience impact, effectiveness of internal processes, and organizational capacities for learning and growth.

a Web site enabling sophisticated comparisons of the performance of U.S. hospitals and other health care providers; and helping to shape the health care agenda of the new federal administration. For all these initiatives, the expected level of progress was achieved.

Because the Fund aims to be a learning organization, it places a high value on assessments of its own performance. Each year, the Board of Directors commissions an external review of a major Fund program, with the goal of assessing performance to date and drawing lessons for the program's future direction. In 2008–09, David Blumenthal, M.D., and Bruce E. Landon, M.D., both of Harvard Medical School, undertook a thorough examination of the foundation's Quality Improvement and Efficiency program, and their findings encouraged the Fund to maintain its efforts to promote health system delivery reform. According to Blumenthal and Landon:

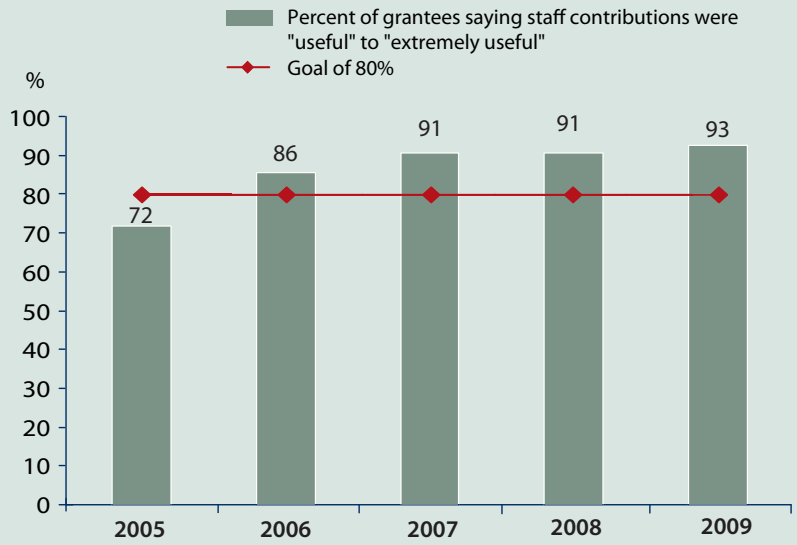
Exhibit 6. Commonwealth Fund Performance Scorecard Metrics: Maintaining a high-quality grants portfolio by selecting capable grantees and ensuring successful projects.



Source: Annual Completed Grants Reports to the Commonwealth Fund Board of Directors.

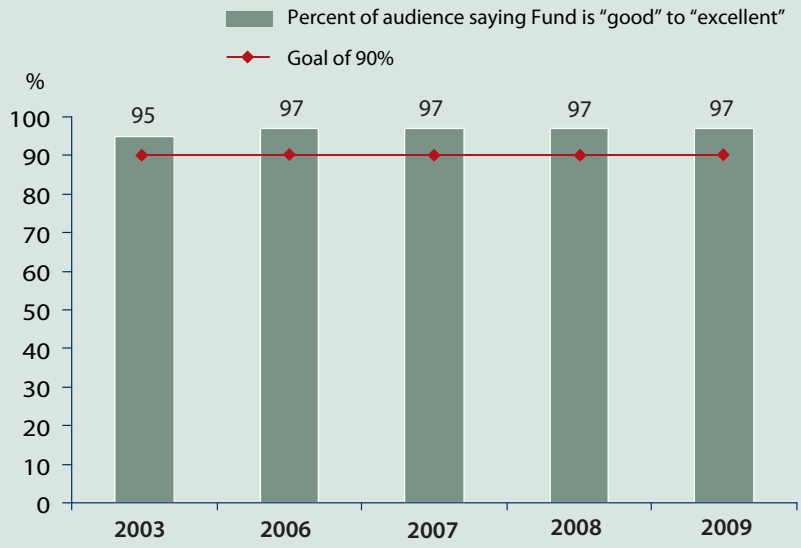
One of the metrics included in the scorecard is the foundation's ability to launch at least four new strategic initiatives each year—with the goal of building on the Fund's record of success and ensuring continued institutional vitality. "Stretch" initiatives for 2008–09 were as follows: launch of the Safety Net Medical Home Initiative; launch of the State Action on Avoidable Rehospitalizations (STAAR) initiative; development of WhyNotTheBest.org,

Exhibit 7. Commonwealth Fund Performance Scorecard Metrics: Adding value to the work of grantees.



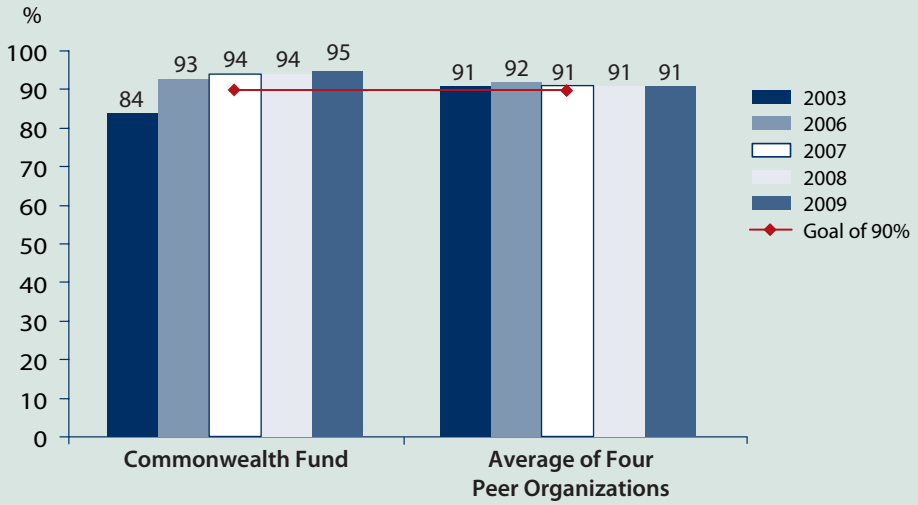
Source: Annual Completed Grants Reports to the Commonwealth Fund Board of Directors.

Exhibit 8. Fund Performance Scorecard Metrics: Providing credible, reliable, timely, and unique information meeting needs of influential customers—audience views.



Source: 2003 Harris Interactive Survey of Fund Grantees and 2006–09 Mathew Greenwald Audience and Grantee surveys.

Exhibit 9. Fund Performance Scorecard Metrics: Providing credible, reliable, timely, and unique information meeting needs of influential customers—audience views.



- Commonwealth Fund activities in the areas of quality improvement and efficiency are widely recognized by key stakeholders, and are thought to have an impact on the field that is disproportionate to the amount of resources expended.
- Despite its relatively small size, the Fund is perceived by respondents to be one of the key organizations supporting the quality improvement and efficiency agenda in the country.
- Improving the capacity for measuring quality and efficiency in health care is seen as crucial to moving this agenda forward. Fund activities related to measurement and implementation have made important contributions, for example, in the areas of patient experiences and measurement at the level of individual physicians and groups.
- The Fund's audience is broadly aware of the foundation's activities in the areas of quality and efficiency. Among those who are aware, these efforts are rated very highly: more than 90 percent of respondents rated performance in each of the main areas as good or better than good.
- The program has a strong record of producing peer-reviewed journal articles and other publications, including 22 papers in top-tier journals and six publications that have been cited more than 100 times. A number of products and publications produced by the program are recognized to be enduring and influential sources of information.

The foundation's system of annual external program reviews, annual reports to the Board on the performance of all grants completed during the year, annual audience and grantee surveys, annual confidential surveys of Fund Board members, and periodic surveys of Fund staff—all of which contribute to the foundation's own annual performance scorecard—help to ensure a high level of accountability and institutional learning that enable the Fund to advance its aspirations for a high performance health care system.

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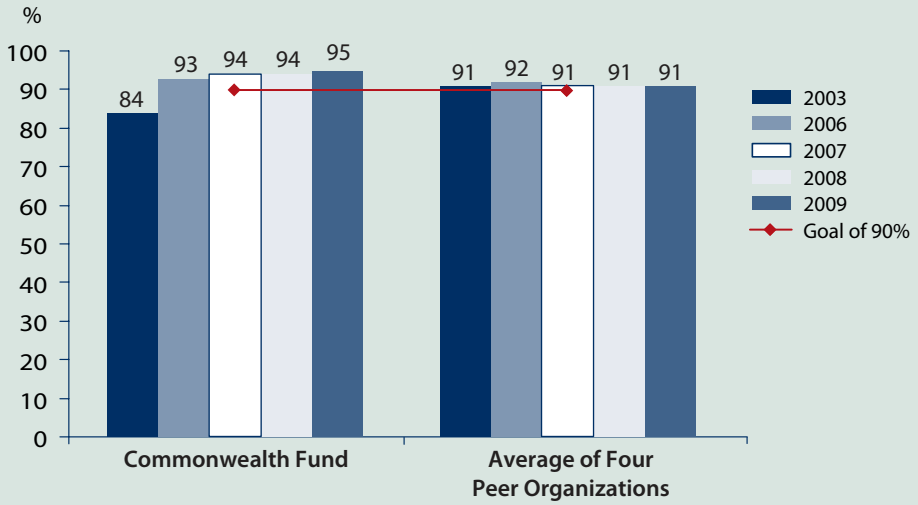

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Commission on a High Performance Health System

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

Commission Goals

In establishing the Commission on a High Performance Health System in 2005, The Commonwealth Fund's Board of Directors recognized the need for national leadership to revamp, revitalize, and retool the U.S. health care system. The Commission's 18 members, a distinguished group of experts and leaders representing every sector of health care, as well as the state and federal policy arena, the business sector, professional societies, and academia, are charged with promoting a high-performing health system that provides all Americans with affordable access to high-quality, safe care while maximizing efficiency in its delivery and administration. Of particular concern to the Commission are the most vulnerable groups in society, including low-income families, the uninsured, racial and ethnic minorities, the young and the aged, and people in poor health.

The Commission's principal accomplishments have been to highlight specific areas where health system performance falls short of what is achievable, and to recommend practical, evidence-informed strategies for transforming the system. Many of the major ideas in the health reform legislation enacted in March 2010—among them, new insurance market regulations, requiring everybody to have coverage, providing premium and cost-sharing subsidies to low- and moderate-income families, and payment and delivery system reforms—were advanced by the Commission through the reports and statements it has issued over the past half-decade.

The Commission is chaired by James J. Mongan, M.D., a member of The Commonwealth Fund's Board of Directors. Fund staff members Stephen C. Schoenbaum, M.D., Cathy Schoen, and Rachel Nuzum serve as executive director, research director, and senior policy director, respectively.

The Issues

The United States provides some of the best medical care in the world, yet a growing body of evidence indicates that our health care system comes up short in comparisons with other industrialized nations. Although health spending in the U.S. is significantly higher than in other advanced countries, we are the only such country that fails to guarantee universal health insurance, and millions of our citizens lack affordable access to primary and acute care. Moreover, the care that is provided is highly variable in quality and often delivered in a poorly coordinated fashion—driving up costs and putting patients at risk.

The new Patient Protection and Affordable Care Act seeks to address these problems. Over the next several years, the Commission will dedicate itself to monitoring the law's implementation and impact, and to recommending modifications that would make the reforms more effective.

Recent Projects

Tracking Health System Performance. In its first report, *Framework for a High Performance Health System for the United States,* published in 2006, the Commission traced the critical sources of health system failures and outlined a vision of a uniquely American, high performance system. Since that initial report, the Commission has issued two national and two state-level scorecards for the U.S. health system. These reports take a broad look at how well the health care system is doing, where improvements are needed, and what examples of good care exist that could serve as models for the rest of the country. They look at specific issues: Do people have access to the health care they need? Are they getting the highest-quality care? Are we spending money and using health care resources efficiently?

The 2008 edition of *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance* finds that in nearly every area of performance measured, the health system performed worse than it did in 2006, scoring just 65 out of 100 across 37 core indicators—where 100 represents not necessarily what is ideal, but what has actually been achieved. Despite some good news in the report—for example, performance on a key measure of patient safety, hospital-standardized mortality ratios, saw significant improvement—the U.S. health system continues to operate far below the performance of leading nations, delivery systems, states, and regions.

The State Scorecard, first published in 2007, offers a metric for evaluating individual states' health care systems on access, prevention and treatment quality, avoidable hospital use and costs, health outcomes, and equity—with the goal of spurring policymakers and private stakeholders to undertake efforts to improve their performance to benchmark levels and beyond. The second edition of *Aiming Higher: Results from a State Scorecard on Health System Performance* reports that the cost and quality of health care, as well as access to care and health outcomes, continue to vary widely among states. An interactive map that accompanies the report provides state-by-state comparisons, as well as estimates of lives and dollars saved if performance were brought up to benchmark levels.

Making the Case for Reform. The Commission believes that while ensuring that all Americans have health insurance is essential, doing so is alone not enough to drive the kind of reform our health system needs. In the 2007 report, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President,* the Commission discusses concrete goals—and the strategies for achieving them—that should be on the national health care agenda, including: guaranteeing affordable health insurance for all; containing growth in health care costs and reforming provider payment; fostering greater organization and integration of care delivery; speeding adoption of health IT, evidence-based medicine, and other infrastructure; and setting and meeting national goals through strong national leadership.

Later in 2007, in *A Roadmap to Health Insurance for All: Principles for Reform,* the Commission makes the case for achieving universal coverage by building on the current mix of private group plans and public programs—a course of action that would retain the best features of our current system while minimizing dislocation for Americans who currently have good insurance coverage.

The Commission also has issued a number of policy reports with specific recommendations for achieving higher system performance. The 2008 report, *Organizing the U.S. Health Care Delivery System for High Performance,* points out the detrimental effects of fragmentation in the current system and offers recommendations for establishing greater coordination across health care providers and care settings. For example, the report recommends moving away from fee-for-service payments and toward bundled payment systems that reward coordinated, high-value care. As

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reported in a Commission data brief, eight of 10 U.S. adults believe the health system needs fundamental change or complete rebuilding, and most want their health care to be more patient-centered and integrated than it currently is.

Developing Policy Options. Certainly one of the most important reports published by the Commission is *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, which lays out in detail federal options for both short- and long-term savings within the health care system. The Lewin Group modeled the likely effects of each option and estimated the five- and 10-year cumulative impact on total national health spending, as well as the effects across federal and state budgets, employers, and households. The analysis determines that if implemented along with universal health coverage, selected policy options could save $1.5 trillion in national health expenditures over 10 years, while also improving the value of care in terms of access, quality, and health care outcomes.

As the national health reform debate began taking shape in February 2008, the Commission released another groundbreaking report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*. The comprehensive insurance, payment, and system reforms described in the paper would guarantee affordable health insurance coverage, improve health outcomes, and slow the growth of health spending by $3 trillion by the end of the next decade, according to projections. Many of the policy options presented are similar to those included in the new health reform legislation.

Informing Policymakers. In addition to formulating policy improvement options and recommendations for health reform implementation, the Commission on a High Performance Health System works to engage and inform policymakers in the executive and legislative branches and key health care stakeholders. The Commission sponsors bipartisan briefings and meetings for members of Congress and their staff. Senior policy director Rachel Nuzum also provides legislators and government officials with testimony and technical assistance as requested.

The Washington-based Alliance for Health Reform receives support from the Fund to conduct the briefings and roundtable discussions, as well as an annual bipartisan congressional retreat and congressional staff retreat, which give members of Congress and their senior staff a unique opportunity for off-the-record discussion of pressing health policy issues.

Future Directions

Even with the passage of comprehensive health care reform**,** the work of the Commission on a High Performance Health System is far from complete. Over the coming months and years the Commission will closely monitor implementation of the reform package, report on areas of concern, and issue recommendations for policy modifications as necessary. Additional, complementary health system reforms also will be studied. Finally, the Commission will continue its efforts to assess national and state health system performance as well as inform health policy at all levels.

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Affordable Health Insurance

Program Goals

The Program on Affordable Health Insurance envisions an efficient and equitable health insurance system that makes available to all Americans comprehensive, continuous, and affordable coverage. In support of that vision, the program seeks to:

- provide timely analysis of changes in private and public insurance coverage for people under age 65 and the impact on the number of people covered and the quality of coverage;
- document the consequences of being uninsured and underinsured on people's health, finances, and productivity; and
- analyze and develop policy options to expand, stabilize, and improve the affordability of health insurance coverage, as well as increase its administrative efficiency.

The program is led by Vice President
Sara R. Collins, Ph.D.

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The Issues

The most recent Census Bureau data show that 46.3 million people lacked health insurance in 2008, an increase of 8 million people since 2000. Moreover, Commonwealth Fund research finds that in 2007 an additional 25 million insured adults under age 65 had such high out-of-pocket costs relative to their income that they could be considered underinsured—up from 16 million in 2003. Both these trends have serious consequences for U.S. families' finances and access to health care, as an estimated 72 million adults under age 65, both with and without health care coverage, reported problems paying their medical bills in 2007, and 80 million reported a time that they did not get needed care because of the cost.

Fortunately, help is on the way. The Patient Protection and Affordable Care Act of 2010, signed into law by the President in March 2010, will in all likelihood significantly improve the affordability and comprehensiveness of nongroup health plans through new insurance market regulations, insurance exchanges, a new standard for health benefits, and sliding-scale premium and cost-sharing subsidies for families with low and moderate incomes, among other reforms. To ensure the law's effective implementation, policymakers will need information about the likely effects of the new reforms on the affordability and quality of coverage, and aspects of the law that might require modification.

Recent Projects

Monitoring Health Insurance Reform

Beginning in 2007, The Commonwealth Fund published a series of reports on the health care reform proposals introduced in Congress, including a report examining in detail each bill's health insurance provisions. Authored by Fund staff, it provided information on the number of people who would likely gain health coverage under the proposals, the estimated insurance premium and out-of-pocket costs for families, the consequences for employers, and the reforms' potential to stimulate price competition and lower costs. In 2008, the Fund published two reports that analyzed the health reform proposals of the presidential candidates. And in 2009–10, the Fund released a series of reports and tables comparing the provisions of the Senate and House health reform bills. After the Affordable Care Act was signed into law by President Obama, the Fund released a set of timelines outlining the provisions of the new law and their expected implementation.

The Fund's Affordable Health Insurance program will be closely monitoring the implementation of the new legislation's provisions and their impact on coverage, affordability, and access to care over the coming months and years (see Future Directions for projects).

Tracking the Uninsured and Underinsured

Each May since 2003, The Commonwealth Fund has published an update of *Rite of Passage: Why Young Adults Become Uninsured and How New Policies Can Help*, to document the crisis in health insurance coverage among U.S. adults ages 19 to 29—the age group with the largest number of uninsured. In the 2009 edition, the authors reported continuing deterioration of coverage, as the number of uninsured young adults climbed to 13.2 million in 2008, up from 10.9 million in 2000. Moreover, nearly half of young adults—some 20 million—are without insurance at some time during the year, according to another Fund study.

The new health reform law will provide significant help to young adults, with reforms enabling them to remain under their parents' coverage until age 26, enroll in Medicaid if their income is at or below 133 percent of the federal poverty level, and buy coverage through insurance exchanges. The Commonwealth Fund will continue to monitor health coverage for this group, focusing especially on the impact of the new federal reforms and additional measures taken by individual states to ensure health security for our nation's young people.

Another group of Americans for whom stable health coverage is rarely a guarantee is older adults in their 50s and 60s—those who are not yet eligible for Medicare. J. Michael McWilliams and colleagues from Harvard Medical School have published several research papers in the *New England Journal of Medicine*, the *Journal of the American Medical Association*, and the *Annals of Internal Medicine* on the use and costs of Medicare services; the health status of Medicare beneficiaries who were uninsured before gaining Medicare coverage at age 65; and the effects of Medicare coverage on disparities in controlling certain chronic diseases. Their most recent study found that Medicare beneficiaries who are uninsured before gaining Medicare at age 65 cost the Medicare system substantially more than the previously insured: $5,796 versus $4,773 per person annually. The findings suggest that providing insurance coverage to uninsured adults in late-middle age could improve their health outcomes while also reducing health care use and spending once they enter Medicare.

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Assessing the Affordability of Health Coverage

Employer-provided health benefits form the backbone of health insurance coverage in America. But recent trends paint a troubling picture for many U.S. workers and their families. In a June 2009 *Health Affairs* article, Commonwealth Fund grantee Jon Gabel, M.A., of the National Opinion Research Center found that the out-of-pocket expenses of enrollees in employer-sponsored health plans grew by more than one-third between 2004 and 2007. The analysis of medical claims and health benefits survey data revealed that the percentage of people with incomes at or above 200 percent of poverty whose expected out-of-pocket spending on premiums and medical services exceeded 10 percent of income—a measure of affordability—rose from 13 percent in 2004 to 18 percent in 2007. Those who were sicker and poorer were more often underinsured, the authors found.

Meanwhile, Commonwealth Fund researchers reported in a September 2009 issue brief that only 25 percent of workers in small firms had coverage through their own employers, compared with 74 percent of workers in large firms. Because there are few sources of affordable coverage outside the employer-based system, millions of employees in small businesses are uninsured or have inadequate health insurance.

Overall, the percentage of Americans facing a high burden of out-of-pocket health care expenses and insurance premiums continues to increase. Writing in *Health Affairs,* Fund grantee Peter J. Cunningham, Ph.D., of the Center for Studying Health System Change reported that in 2006, nearly one of five Americans—19 percent of the nonelderly population—lived in families spending more than 10 percent of before-tax income on health care, up from one of seven Americans in 2001. The study found that in all income brackets, people with private insurance experienced an increase in their health care–related financial burden between 2004 and 2006, with the greatest increase occurring among middle- and higher-income individuals. Cunningham also found substantial variation in out-of-pocket burdens across the states.

In a Fund issue brief published in 2009, Cunningham found that an alarmingly high proportion of adults with multiple chronic conditions had a high level of out-of-pocket expenses and premiums. Looking specifically at the nonelderly population, he found that for nearly 40 percent, such expenses exceeded 5 percent of their income for two consecutive years, compared with 14 percent of those who had no chronic conditions. Prescription drug spending accounted for more than half of the out-of-pocket spending by these individuals.

Examining Efficiency in Health Insurance

Administrative expenses are a major culprit in the growth of health care costs over the years. Physicians spend an average of 142 hours interacting with health insurance plans annually, at an estimated annual cost to physician practices of more than $68,000 per physician per year, according to a Fund-supported study in *Health Affairs* led by Lawrence Casalino, M.D., Ph.D., of Weill Cornell Medical College. Meanwhile, the costs of billing and insurance tasks in a large medical group practice consume $85,276 per full-time equivalent physician, or 10 percent of operating revenue, as determined by Harold Luft, Ph.D., of the University of California, San Francisco, and colleagues in another *Health Affairs* study.

An issue brief published by The Commonwealth Fund in July 2009 showed how insurance market reforms similar to those included in the new health reform law could substantially lower such costs. The authors, led by Fund vice president Sara Collins, Ph.D., found that as much as $265 billion could be saved over the period 2010 to 2020 if insurance companies reduced their marketing and underwriting, lowered the costs of claims administration, spent less time negotiating provider payment rates, and reduced or standardized commissions to insurance brokers.

High administrative costs are a central reason why the premiums and deductibles of health plans offered in the individual market are unaffordable for many adults. Commonwealth Fund researchers reported in *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families* that between 2006 and 2009, nearly three-quarters of people who tried to buy coverage in the individual market never actually purchased a plan, either because they could not find one that fit their needs or that they could afford, or because they were turned down because of a preexisting condition—an insurance company practice that is now banned under health reform.

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Future Directions

The Commonwealth Fund's Program on Affordable Health Insurance will monitor the impact of the Affordable Care Act on the nation's uninsured and underinsured and inform policymakers and federal officials about ways to ensure the reforms are as effective as they can be.

The Fund is supporting a number of projects to inform policymakers and the public about health reform and to help ensure it accomplishes its goals. Timothy Jost, J.D., of the Washington and Lee University School of Law, in collaboration with Mark Hall, J.D., of Wake Forest University, and Katherine Swartz, Ph.D., of the Harvard School of Public Health, will examine the creation of state insurance exchanges—which will allow individuals to shop for their health coverage—and inform state and federal officials, legislators, and regulators about ways to make them as effective as possible. The National Opinion Research Center's Jon Gabel will be estimating the affordability of health plans available through the exchanges, as well as the cost protection these plans provide. Gabel will also attempt to develop an efficient mechanism for taxing high-cost plans that provide rich benefits.

Using "micro-simulation modeling," Harvard University's Jonathan Gruber, Ph.D., will examine the cost and coverage implications of various policy options for helping states move forward on reform prior to 2014. The findings could aid the development of additional policies to provide relief for uninsured and underinsured families in the four-year period preceding full implementation of health reform.

Pamela Farley Short, Ph.D., of the Pennsylvania State University will estimate gaps in people's health coverage and the extent of churning in plan enrollment over the 2004–2007 period; these findings will provide policymakers with a baseline for evaluating the capacity of health reform to address the problem. And Jean Hall, Ph.D., of the University of Kansas Center for Research will study the high-risk insurance pools created by the new law and offer recommendations to officials charged with their implementation.

Throughout the implementation of the Affordable Care Act, The Commonwealth Fund will issue analyses of how the law's provisions are designed to benefit different groups of Americans, such as young adults and small business owners.

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State Health Policy

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Program Goals

The Commonwealth Fund launched the Program on State Health Policy to help states implement programs and policies that ensure residents have access to affordable, high-quality health care. The program does this by:

- working with state-initiated public–private partnerships to develop the policies and infrastructure necessary to improve quality of care and ensure greater accountability for patient outcomes; and
- disseminating lessons from the experience of states as they implement comprehensive health care reform.

The Issues

Today's economic environment has both increased the pressure on states to reform their health systems and made it more challenging for state leaders to find the resources to do so. The Fund's State Health Policy Program was established to help states develop the infrastructure needed to improve the quality of their health care—and to share lessons of national import drawn from the experience of states pursuing comprehensive health reforms.

The program is led by Vice President
Edward L. Schor, M.D.

Promoting greater collaboration between the public and private sectors is one of the keys to improving the capacity of health care providers, particularly those serving vulnerable populations, to achieve high performance. Another strategy is helping state leaders share information on the policy and practice innovations they are undertaking.

Recent Projects

Working with Public–Private Partnerships

Providing technical assistance for quality improvement. In 2008, The Commonwealth Fund and AcademyHealth launched the State Quality Improvement Institute (SQII) to help states address some of the shortcomings in performance highlighted by the Fund's State Scorecard on Health System Performance. Nine states—Colorado, Kansas, Massachusetts, Minnesota, New Mexico, Ohio, Oregon, Vermont, and Washington—were selected to participate in an intensive process of state-level planning and engagement with expert faculty to facilitate reform efforts.

The SQII has facilitated communication between high-level state participants and expert faculty to improve care in three priority areas: delivery and financing system reform, chronic care and population health improvement, and data integration and transparency. Following a planning phase, SQII states began the process of implementing action plans around specific improvement strategies, including: implementation of medical homes and care coordination strategies, adoption of population health initiatives to reduce chronic disease risk in the community, better chronic disease management to improve health outcomes and avoid costly hospitalization and rehospitalization, and use of data for performance improvement and public reporting. The SQII's expert faculty is working closely with multi-stakeholder state teams to identify and adopt evidence-based models for systemic transformation. A one-year progress report is available on the AcademyHealth Web site.

Improving care coordination, case management, and linkages to community services. The first two Assuring Better Child Health and Development (ABCD) initiatives, supported by The Commonwealth Fund, have helped 25 states launch projects to promote the use of structured developmental screening for young children through policy and physician practice change. As practitioners have stepped up their identification of young children with developmental concerns, however, they have been presented with a new challenge: referring families to appropriate intervention services and coordinating their care with other developmental service providers. To address these issues, the most recent ABCD initiative led by the National Academy for State Health Policy (NASHP) is engaging five states—Arkansas, Illinois, Minnesota, Oklahoma, and Oregon—in efforts to change their policies, develop programs, and work with physician practices to create the systemic changes needed for effective coordination and referral networks. NASHP is also continuing to support states' efforts to sustain their achievements in expanding developmental screening.

In an April 2009 Commonwealth Fund report, Kay Johnson and Jill Rosenthal show how states can help reduce barriers to greater integration of services delivered by physician practices and community referral and resource agencies. The authors outline a number of strategies states can adopt, such as offering medical home providers financial incentives and other support for care planning and case management, electronic medical record systems, and individualized, patient-centered care plans.

Helping to implement reforms in physician practices. To help physician practices make the changes needed to improve quality and efficiency, the Fund is supporting the development of statewide, multi-stakeholder collaborations called "improvement partnerships." The Vermont Child Health Improvement Program (VCHIP), the first of these initiatives, is assisting public–private partnerships in 19 states. An online guide available on the VCHIP Web site provides state leaders in child health with step-by-step instructions on developing sustainable collaborations of public and private partners. Along with the American Academy of Pediatrics and the National Initiative for Children's Healthcare Quality, the Fund sponsored a webinar in September 2009 where representatives from three improvement partnerships described how their initiatives have improved care at the practice level and influenced state policy.

Promoting state and federal dialogue. Successful implementation of health care reform will require committed, informed leadership within each state. With Fund support, the National Academy for State Health Policy is testing a model for fostering dialogue between state and federal leaders on issues related to health system performance. An October 2009 meeting of state and federal leaders in Washington, D.C., focused on patient safety and nonpayment for adverse medical events. (See this NASHP report for more information.)

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Disseminating Lessons Learned

With a circulation of some 15,000, the Commonwealth Fund e-newsletter States in Action: A Bimonthly Look at Innovations in Health Policy tracks and reports on promising state initiatives to improve health system performance. Prepared by Sharon Silow-Carroll and her team at Health Management Associates, the newsletter helps policymakers, administrators, and researchers as they work to stretch health care dollars and meet the needs of their residents.

In 2009, the National Governors Association launched a $1.5 million national initiative, Rx for Health Reform: Affordable, Accessible, Accountable, to assist governors and other state leaders in developing coordinated, efficient health care systems in the context of the new federal health reform law. The Fund is providing support for a series of papers analyzing the legislation and its implications for states, informing state activities as the law's provisions are implemented. Paper topics include health insurance reform, changes to the Medicaid program, establishing state-level exchanges, and delivery system redesign.

While states have been regulating private health insurance companies and products for a century, state regulatory activity has not addressed insurers' obligations regarding health care affordability and cost containment. A project undertaken by Michael Bailit, M.B.A., of Bailit Health Purchasing, LLC, resulted in a Fund issue brief that describes Rhode Island's innovative use of health insurance statutes and regulations to promote system reform by addressing the need for expanded primary care capacity and primary care delivery change.

Future Directions

The State Health Policy program will continue to help states network practices and providers through shared resources and unified approaches to paying providers and improving quality of care. The program will also build on the Fund's experience with monitoring, evaluating, and reporting on health system innovation and performance. Grants will support projects that analyze states' capacity to adopt significant payment reform, integrate Medicaid into statewide reforms, and help state hospitals, physicians, and insurers work together. The program also will support technical assistance, such as case studies and meetings to inform state leaders about health care reform and help them share their experiences with federal policymakers.

For example, a grant led by Nikki Highsmith of the Center for Health Care Strategies is helping to advance primary care transformation in Medicaid. Already the nation's largest health coverage program, Medicaid will be significantly expanded as part of the new health reform law, and new ways are needed to improve the efficiency and effectiveness of the small primary care practices that provide much of the care for Medicaid patients, particularly in underserved areas. The Fund grant has supported interviews with Medicaid leadership in several states to determine how they are supporting small practices and to identify funding strategies and essential partnerships needed to support them.

The ABCD initiative, meanwhile, will continue to work with leaders from Arkansas, Illinois, Minnesota, Oklahoma, and Oregon to make policy changes, develop programs, and collaborate with physician practices to create the systemic changes needed for effective coordination and referral networks for children with developmental problems.

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Payment System Reform

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Program Goals

The Program on Payment System Reform supports analysis and the development of policy options to curb health spending growth and improve the way health care is provided. Its goal are to:

- improve the existing payment structure to better align incentives and to provide a base for more comprehensive payment reform;
- model and analyze the potential impact of alternative options for payment reform in Medicare and throughout the health system;
- use payment reform to encourage the development of new models of health care delivery that provide better and more-coordinated care, while reducing cost growth; and
- evaluate new approaches to health care payment and delivery to determine their potential use as models for broader application.

The program is led by Assistant Vice President Stuart Guterman.

The Program on Payment System Reform grew out of the Fund's former Program on Medicare's Future, which was dedicated to improving Medicare's ability to protect access to care for the nation's elderly and disabled and enhancing Medicare's role as a platform for efficiency and quality improvements that could be applied to the health care system as a whole.

The Issues

The U.S. health care system is the most expensive in the world. National health spending is projected to double from $2.5 trillion in 2009 to $5.0 trillion—21.3 percent of our nation's gross domestic product—by 2020. Yet this high level of spending does not produce commensurate returns in access, health outcomes, or value. To achieve a high-performing health system, we must curb spending growth and improve the way health care is provided. Payment system reform is critical to accomplishing these objectives. As a nation, we need to align incentives so that health care providers are rewarded for delivering high-value care rather than a high volume of services. Rewarding value over volume will also encourage the development of a more integrated health care delivery system.

New Projects

Practice-level risk adjustment for health care reform. Researchers led by Arlene Ash, Ph.D., of the University of Massachusetts Medical School at Worcester are developing a practical, generalizable approach for making risk-adjusted payments and measuring and rewarding quality for groups of primary care providers that are functioning as patient-centered medical homes.

Promoting integrated delivery systems for Medicare's most vulnerable beneficiaries. Melanie Bella, M.B.A., and colleagues at the Center for Health Care Strategies are providing technical assistance to seven states as they develop and implement mechanisms to realign conflicting incentives between Medicare and Medicaid in the treatment of "dual eligible" beneficiaries who are enrolled in both programs.

Using cost-effectiveness research to improve value in Medicare. A research team led by Peter Neumann, Sc.D., of Tufts Medical Center is examining opportunities to improve the value of Medicare spending by identifying services with high costs relative to the outcomes they achieve, as well as services that could produce more-cost-effective outcomes. The researchers will also develop estimates of the savings and improved outcomes that are possible from allocating Medicare resources more appropriately.

Reforming Medicare's benefit structure and provider payment system. The Urban Institute's Stephen Zuckerman, Ph.D., and his colleagues are investigating policy options for helping low-income beneficiaries access a more unified and comprehensive set of Medicare benefits. They also are developing and modeling the impact of approaches to improving the way Medicare pays physicians.

Modeling the impact of payment reforms. With Fund support, Allen Dobson, Ph.D., of Dobson DaVanzo & Associates is seeking to understand how the expansion of insurance coverage under health reform will affect providers. Specifically, the project is estimating how the availability of payment for patients who currently have no insurance will affect hospitals, including the impact that alternative payment levels will have on total hospital revenues and net revenue margins across different types of hospitals and hospitals in different geographical areas. The analysis also will gauge the potential impact of alternative levels of payment from Medicare and Medicaid on the level and distribution of hospital payments and margins.

Analyzing Medicare's payment policy for hospital-acquired conditions and its impact on safety-net hospitals. The Centers for Medicare and Medicaid Services (CMS) has specified a list of avoidable hospital-acquired medical conditions that it will no longer consider in determining payment for inpatient hospital stays. A team led by Megan McHugh, Ph.D., of the Health Research and Educational Trust is examining the potential impact of Medicare's new payment policy on hospital-acquired conditions in safety-net and other hospitals. McHugh and her colleagues also will identify strategies that different types of hospitals are using to respond to the policy, reduce the incidence of hospital-acquired conditions, and develop quality improvement programs.

Modeling the impact of Medicare payment rate updates. Researchers led by James Reschovsky, Ph.D., of the Center for Studying Health System Change are developing a model to assess the potential effects of proposals to link Medicare payment rate updates to variations across communities in the cost of treating Medicare beneficiaries.

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Assessing the value of Medicare Advantage plans for beneficiaries. For several years, George Washington University's Brian Biles, M.D., M.P.H., has been examining the Medicare Advantage program for private plans to determine the magnitude of plan payments relative to the costs these plans face; what the Medicare program and its beneficiaries receive for those payments; and the implications of alternative payment policies.

Future Directions

In the post-health reform world, projects supported by the Program on Payment System Reform will work to build capacity for modeling the impact of payment system reforms, as well as federally mandated demonstrations and pilot projects, on groups of providers and the health system overall. The grants it supports also will seek to improve the process for the rapid-cycle development, testing, and implementation of payment system improvements; conduct evaluations of local initiatives aimed at changing payment incentives; and improve the performance of the health care delivery system.

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Health Care Quality Improvement and Efficiency

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Health Care Quality Improvement and Efficiency

Program Goals

The goal of The Commonwealth Fund's Program on Health Care Quality Improvement and Efficiency is to improve the quality and efficiency of health care in the United States. The program is rooted in the belief that improvements are most likely to occur when the need for change is understood, measured, and publicly recognized; when providers have the capacity to initiate and sustain change; and when appropriate incentives are in place. To that end, the program supports projects that:

- promote the development and widespread adoption of measures of health care quality and efficiency;
- assess and enhance the capacity of health care organizations to provide better care more efficiently; and
- promote the development and adoption of payment and incentive models that encourage health care providers to improve quality and efficiency.

Vice President Anne-Marie J. Audet, M.D., leads the program.

The Issues

The quality and efficiency of American health care is not what it should be. Despite the skill and dedication of the nation's health care providers, ample opportunities for improvement exist in a number of quality domains, including receipt of the "right care"—the most effective and appropriate care for a given medical condition—and care that is safe, timely, well-coordinated, and patient-centered. According to The Commonwealth Fund's 2008 National Scorecard on U.S. Health System Performance, up to 101,000 deaths could be prevented each year if the United States were able to raise standards of care to the benchmark levels achieved by the top-performing countries.

The relatively poor performance of the health system in the U.S., coupled with the nation's standing as the biggest spender on health care in the world, also suggests it is a highly inefficient one. Indeed, evidence of overuse of health services, inappropriate care, and waste abounds. Supporting efforts to increase the value obtained from our health care dollars is one of the Fund's chief goals.

Recent Projects

Redesigning Care for High Performance. Hospitalizations consume nearly one-third of the $2 trillion spent on health care in the U.S. Many of these are readmissions for conditions that could have been prevented with proper discharge planning by hospitals and adequate education and post-discharge support for patients.

In May 2009, the Institute for Healthcare Improvement (IHI), with Commonwealth Fund support, initiated the first phase of the State Action on Avoidable Rehospitalizations (STAAR), a multipronged effort to help hospitals improve their processes for transitioning discharged patients to other care settings. In addition to helping hospitals and other providers improve post-discharge support, multidisciplinary disease management, and patient education, STAAR is assisting state policymakers and other stakeholders in implementing systemic changes to sustain these improvements. These changes might take the form of requiring payers to track and report readmission rates, or trying out new provider payment models that reward the coordination of patient services across the care continuum. Under the direction of IHI staff, the initiative has been launched in three states—Massachusetts, Michigan, and Washington.

A concurrent Fund-supported evaluation of STAAR by Pennsylvania State University's Dennis Scanlon, Ph.D., is assessing how well the interventions succeed in reducing hospital readmission rates. The results should hold interest for the Medicare program and other public and provider payers for which reducing hospitalizations is a priority.

To help hospital leaders get started on a plan for reducing readmissions, a team of experts at the Health Research & Educational Trust (HRET) of the American Hospital Association, the John A. Hartford Foundation, and The Commonwealth Fund produced the Health Care Leader Action Guide to Reduce Avoidable Readmissions. This quick, simple resource outlines strategies that have been proven successful in reducing unplanned readmissions and estimates the level of effort required for hospitals to implement the strategies.

Another major source of health care spending is the care provided to patients with chronic health conditions. Fund grantees Greg Pawlson, M.D., of the National Committee for Quality Assurance and Robert Berenson, M.D., of the Urban Institute conducted a survey of 31 health plans' organizational characteristics and activities to see how resource use in diabetes care corresponds with patient outcomes. Their findings, published in an article in the *American Journal of Medical Quality*, show that variation in the level of resources used to care for patients varied considerably more—as much as three to five times more—than the quality of care delivered. The findings suggest that efforts to make health care delivery more efficient do not require sacrificing the quality of patient care.

Meeting and Raising Benchmarks for Quality. At the end of 2008, The Commonwealth Fund launched a new benchmarking and quality improvement resource, the Web site WhyNotTheBest.org, which enables health care professionals to compare their organization's performance against a range of benchmarks and access case studies and improvement tools. This unique resource has since developed a wide following. More than 7,500 registrants now use the site to search for hospitals by name, region, and various characteristics, choose from an array of performance benchmarks, and save reports for future visits. Here are just some of the performance data to be found on WhyNotTheBest.org:

- Hospital Quality Alliance measures that report how often hospitals follow recommended care processes for heart attack, heart failure, pneumonia, and surgical care improvement;

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- findings from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which surveys recently discharged patients about important aspects of their hospital experience;
- Medicare patient readmissions within 30 days of discharge from a previous hospital stay for heart attack, heart failure, or pneumonia, as well as risk-adjusted, 30-day mortality for these three conditions; and
- standardized rates for central line–associated bloodstream infections, an often deadly hospital-acquired complication.

WhyNotTheBest.org also has over 30 case studies of high-performing hospitals and integrated delivery systems and more than 45 improvement tools. Site enhancements over the next year will add key measures obtained from new state all-patient data sources, as well as sophisticated "dashboards" that provide a compelling overview of performance.

Assessing Providers' Capacity to Improve Care. For the nation's health care providers to attain performance benchmarks like those reported on WhyNotTheBest.org, they must have the capacity—the knowledge, infrastructure, and incentives—to do so. The first National Survey of Physician Organizations, conducted in 2000, found that most group practices were not taking of advantage of evidence-based care management processes shown to improve treatment of patients with chronic illnesses—and that the lack of payment incentives and health information technology were partly to blame.

With Commonwealth Fund support, Stephen Shortell, Ph.D., and his colleagues at the University of California, Berkeley, conducted the second round of the survey to assess progress made in chronic disease management. Results from the study indicated that between 2000 and 2006, the use of 17 chronic disease management processes, such as disease registries, patient reminders and other attributes associated with the medical home model of care, increased by 23 percent. Practices participating in quality improvement activities, those receiving financial rewards linked to quality, and those that were profitable showed the greatest increase in use. The study produced a number of peer-reviewed papers, including a September 2008 *Health Affairs* article.

Hospitals also need to make quality improvement a more integral component of their culture. A Fund-supported study led by Alan B. Cohen, Sc.D., of Boston University and colleagues surveyed top quality officers at 470 U.S. hospitals to examine the extent to which hospitals are embracing the principles and methods of quality improvement, or QI. Cohen and his colleagues found that top hospital executives, managers, and nurses are far more engaged in QI activities than physicians—a finding consistent with studies citing the lack of doctors' involvement in quality-focused activities as a barrier to improvement. The researchers have since visited a selection of top-performing hospitals, as well as hospitals with "average" outcomes, and interviewed executives, financial officers, and frontline staff to determine what is driving variations in quality. Case studies of these sites are forthcoming later in 2010.

Disseminating Best Practices and Innovative Models

Multi-hospital health systems are the most common organizational structure in the hospital industry—the 250 largest hospital systems accounting for more than half of all hospital admissions in the United States—and they play an important role in strengthening the quality and safety of patient care. With Commonwealth Fund support, a team led by HRET president and American Hospital Association senior vice president Maulik Joshi, Dr.P.H., identified the characteristics and practices of high-performing hospital systems and developed recommendations to help underperforming systems make necessary changes. The publication that resulted, A Guide to Achieving High Performance in Multi-Hospital Health Systems, is intended to inform system leaders about what they can do to ensure that patients across all of their hospitals receive the highest quality care available. The resource provides nearly 20 best practices in four crucial areas: establishing a system-wide strategic plan, with perfection as the ultimate goal; creating alignment between goals and incentives; leveraging data and measurement across the organization; and standardizing and spreading best practices across the system.

Conducting case studies of high-performing provider organizations is another way to educate health care stakeholders about best practices for managing chronic diseases, reducing hospitalizations, increasing patient satisfaction, and achieving other important performance goals. In addition to the hospital case studies available on WhyNotTheBest.org, the Fund also has made available a series on organized delivery systems across the U.S. In a report synthesizing findings from the cases, Douglas McCarthy and colleagues explore the attributes common to many of the standout organizations examined, including information continuity, a high level of patient engagement, an emphasis on coordinated care, team-oriented care delivery, continuous innovation and learning, and convenient access to care.

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Future Directions

Reforming provider payment, increasing "transparency" with regard to quality and cost, and engaging patients more in their care are the focus of key provisions in the health reform legislation passed in March 2010, and lessons learned from projects funded by The Commonwealth Fund in these areas will inform the implementation of a number of the law's provisions.

Having supported the evaluation of some of the first pay-for-performance programs in the nation, the Fund is turning to more sophisticated payment models, like the Alternative Quality Contract being implemented by Blue Cross Blue Shield of Massachusetts. Under this new system, the hospitals and physicians caring for a patient throughout the course of an illness are provided a monthly, risk-adjusted global payment that covers all services delivered; performance-based payments supplement the baseline payment. With Fund support, Michael Chernew, Ph.D., of Harvard Medical School is currently assessing whether the new payment method improves the quality of patient care and controls costs.

Other Fund grants in the areas of health care quality improvement and efficiency include an evaluation, led by Geoffrey Lamb, M.D., of the Wisconsin Collaborative for Healthcare Quality, which is one of the U.S. Department of Health and Human Services' designated Chartered Value Exchange Networks and a leader in public reporting and sharing of best practices. Another evaluation will examine shared decision-making in primary care and specialty clinics that are part of the Group Health Cooperative's network in the state of Washington. Headed by David Aterburn, M.D., M.P.H., the project will assess the effectiveness of 12 patient-decision aids on the use of elective surgical procedures, total health care utilization, and total costs.

To apply for a grant from The Commonwealth Fund's

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Patient-Centered Coordinated Care

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Program Goals

As defined by the Institute of Medicine, patient-centered care is "health care that establishes a partnership among practitioners, patients, and their families . . . to ensure that decisions respect patients' needs and preferences, and that patients have the education and support they need to make decisions and participate in their own care." In primary care, such care is best delivered in a medical home—a primary care practice or health center that provides patients with enhanced access to their clinicians, coordinates all care, and engages in continuous quality improvement.

The goal of The Commonwealth Fund's Program on Patient-Centered Coordinated Care, established in 2005, is to improve the quality of primary care by making it more patient- and family-centered. The initiative supports projects that:

- promote the collection of information on patient-centered care and the delivery of care to facilitate public reporting and quality improvement;
- stimulate adoption of effective practices, models, and tools to make primary care practices patient- and family-centered; and
- improve policy to encourage patient- and family-centered care in medical homes.

The program is led by Assistant Vice President Melinda K. Abrams, M.S.

Recent Projects

Testing and measuring the medical home. In April 2008, The Commonwealth Fund awarded a grant to Qualis Health, a nonprofit quality improvement organization based in Seattle, to run the Safety-Net Medical Home Initiative, a five-year demonstration project. The investigators are seeking to transform more than five dozen primary care clinics serving predominantly Medicaid-enrolled or uninsured patients into patient-centered medical homes that achieve benchmark levels of quality, efficiency, and patient experience. Led by Qualis Health president and CEO Jonathan Sugarman, M.D., and Ed Wagner, M.D., of the MacColl Institute for Healthcare Innovation, the research team selected five states for participation: Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania.

The Commonwealth Fund is joined in its support of the project by eight cofunders: the Colorado Health Foundation, Jewish Healthcare Foundation (Pittsburgh), Northwest Health Foundation (Portland, Ore.), Partners HealthCare (Boston), Blue Cross Blue Shield of Massachusetts Foundation, Blue Cross of Idaho, the Boston Foundation, and Beth Israel Deaconess Medical Center (Boston).

Marshall Chin, M.D., and a team of researchers at the University of Chicago were awarded a Fund grant to evaluate whether the participating clinics, in fact, become medical homes, how medical homes affect quality and efficiency, and what factors are associated with a clinic's successful implementation of this care model. Although individual components of the medical home have been associated with a number of positives—higher-quality care, lower costs, and higher satisfaction for patients and practice staff, among them—there have been no previous evaluations of the model as a whole.

To build an empirical basis for the medical home concept—as well as to assess the viability of implementing it—the Fund also is supporting several other evaluations of ongoing medical home demonstrations, including ones in New York, Massachusetts, and Rhode Island. Using a variety of methods, the research teams are looking into whether: 1) physician offices are able to make the changes necessary to function as medical homes; and 2) physician offices that receive technical assistance and a revised payment structure improve their performance on measures of quality, efficiency, patient experience, and physician and staff satisfaction.

The Commonwealth Fund also is supporting efforts to identify and "measure" medical homes. With previous Fund support, the National Committee for Quality Assurance (NCQA) worked with the nation's leading primary care specialty societies to develop practical criteria for assessing and recognizing physician practices as patient-centered medical homes. Eighteen patient-centered care measures have now been incorporated into the standards for NCQA's Physician Practice Connections—Patient-Centered Medical Home program. Supported by a subsequent Fund grant, Sarah Scholle and her colleagues at NCQA are developing and testing additional medical home measures related to the quality of patient–physician communication, family and community involvement in care, patient self-management, and care coordination.

Helping practices become medical homes. The Patient-Centered Coordinated Care program also is supporting efforts to promote practices, models, and tools that will help individual primary care practices become more patient-centered. For example, the Fund is supporting an evaluation of the American Academy of Family Physicians' TransforMED demonstration, in which three dozen practices implement a comprehensive set of innovations to improve health care quality, safety, efficiency, patient-centeredness, access to care, and information systems.

In a paper published in the March 2008 issue of *Family Practice Management,* the research team, led by Carlos Jaén, M.D., Ph.D., of the University of Texas Health Sciences Center at San Antonio, discussed a survey of patients served by the three dozen physician practices in the program and created a protocol to help clinicians address patients' concerns and meet their care needs and expectations. The protocol, which has been shown to increase patients' satisfaction without increasing the length of visits, asks physicians to: 1) inquire into all of the patient's concerns; 2) develop a working agenda together; 3) sort through the patient's concerns; and 4) structure the office visit accordingly.

Given the growing interest in medical homes for Medicaid populations, state Medicaid officials require guidance in implementing medical home models and devising payment systems that will support the process. To assist them, Neva Kaye and the National Academy for State Health Policy (NASHP) are working with state Medicaid officials to inform policymakers of the benefits of patient-centered medical homes, promote financing and policy options for implementing them, and track

states' implementation efforts. In 2008, NASHP provided technical assistance to Medicaid and state officials from eight states—Colorado, Idaho, Louisiana, Minnesota, Oklahoma, Oregon, New Hampshire, and Washington—on ways to advance the medical home model. The lessons from working with these states are described in a Commonwealth Fund/NASHP report from June 2009.

What does it cost to make the transformation into a medical home? A project sponsored jointly by The Commonwealth Fund and the American College of Physicians (ACP) sought to address that question and develop payment options in support of medical home adoption. Based on data collected from some three dozen practices, the researchers, led by Robert Berenson, M.D., of the Urban Institue, found no evidence of additional costs associated with increasing levels of "medical home intensity," with the exception of information technology costs (see their report). Berenson argues that in addition to costs and quality of care, evaluations of the many ongoing demonstrations of the medical home model should focus on payment design. In an article in the Journal of General Internal Medicine coauthored with Katie Merrell, he examines the strengths and weaknesses of the predominant medical home payment approaches.

Future Directions

The new health reform law includes provisions to strength primary care and provide funding for medical homes. To help ensure the success of medical home initiatives, The Commonwealth Fund will continue to address outstanding questions about medical homes as well as test the model—particularly in safety-net practices and settings where patients with chronic conditions receive care.

The Pennsylvania Chronic Care Initiative, the most extensive multipayer medical home demonstration program in the nation, is testing the effectiveness of four models for financially rewarding primary care sites that function as patient-centered medical homes. A Fund-supported team of RAND and Harvard University researchers headed by Mark W. Friedberg, M.D., M.P.P., is assessing the differential impact of these payment approaches—which range from per-member per-month care management fees to shared savings—on health care utilization, efficiency, cost, and quality of care.

Ann S. O'Malley, M.D., M.P.H., of the Center for Studying Health System Change (HSC), meanwhile, is studying primary care sites that either directly provide effective, efficient after-hours care primary care or coordinate such care with a patient's usual primary care provider. Through case studies and interviews, her team will identify the factors associated with successfully providing such care, particularly focusing on policies and practice characteristics that could facilitate replication of effective models.

Another grant to HSC, led by Hoangmai H. Pham, M.D., M.P.H., is supporting research into how independent primary care practices construct and implement care coordination agreements and how useful they find them to be when collaborating with specialty care practices, hospitals, home health agencies, and nursing homes. The findings will help providers use these agreements more effectively and could facilitate implementation of accountable care organizations and bundled payment systems that rely on well-coordinated care.

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Quality of Care for Frail Elders

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Program on Quality of Care for Frail Elders

Program Goals

As our population ages, long-term care is becoming a familiar concept to many Americans. Nearly everyone knows someone who has spent time in a nursing home or assisted living facility, or who receives home health care. As part of its work to help bring about a high performance health system, The Commonwealth Fund strives for high performance in long-term care. The Picker/Commonwealth Fund Program on Quality of Care for Frail Elders does this by supporting projects that:

- identify, test and spread effective, person-centered practices, models, and tools;
- help nursing homes become high performance organizations; and
- track and respond to policy issues and health care system trends that affect long-term care.

The Frail Elders program, which builds on the Fund's longstanding interest in promoting person-centered care, is led by Assistant Vice President Mary Jane Koren, M.D., M.P.H.

The Issues

In hospitals, clinical excellence and safety are paramount. But in nursing homes, high-quality clinical care is only half the story; equally important is making residents feel comfortable and "at home." Although the 1987 Nursing Home Reform Law underscored the importance of quality of life and the preservation of residents' rights, serious concerns remain about the quality of the majority of the nation's 15,800 nursing homes. Moreover, chronic staff shortages and high turnover rates exacerbate existing problems and hamper efforts to improve performance.

The grassroots movement to bring about culture change in nursing homes has made great strides in overcoming these problems, many of which are rooted in an overriding concern with institutional efficiency. The goal of culture change is "person-centered" care, and it requires a fundamental shift from thinking of nursing homes as medical facilities that house frail older people, to conceiving of them as real homes where residents can also receive health services. A growing body of evidence is revealing that nursing homes that have undergone culture change—such as those following the Eden Alternative or Green House models—are not only better for the people who live and work there, but they are also economically viable.

Recent Projects

Advancing Excellence in America's Nursing Homes: The Nursing Home Quality Campaign. Advancing Excellence is a voluntary, coalition-led effort that builds on the success of the culture change movement and other quality initiatives. Launched in 2006 with Commonwealth Fund support and headed by a national steering committee of 25 organizations comprising nursing home associations, health care professionals, direct-care worker representatives, consumer advocacy groups, and government agencies, the campaign is helping nursing homes to improve the quality of care for residents and the quality of life of both residents and staff. To join the campaign, nursing homes must select at least three of the campaign's eight goals, which represent key indicators of clinical quality—like better pain management, fewer pressure ulcers, and reduced use of physical restraints—and organizational improvement, such as lower turnover rates for staff.

As of October 2009, 47.6 percent of America's 15,800 nursing homes have signed onto Advancing Excellence. Consumers and nursing home staff are also welcome to participate. Through its Web site and the 49 state-based networks (known as Local Area Networks for Excellence), the campaign is lending technical assistance to providers to help them with their improvement efforts. More than two years of data tracking progress toward clinical goals show that nursing homes participating in the campaign are improving at a faster rate than those that are not.

Commonwealth Fund grants have enabled the campaign to hire a national director and a field director for the state networks. Fund support has also allowed the campaign to sponsor free online seminars to assist nursing homes in meeting their quality goals. Some of the webinars have attracted more than a thousand participants.

Pioneer Network. The Pioneer Network, which has spearheaded the culture change movement since 1997, is making progress on several fronts. The organization is reaching out to providers across the country to offer training, practical tools, and resources, and it is serving as a community of peers for those trying to transform their facilities. In addition, Pioneer is helping to eliminate some of the barriers to the adoption of person-centered care. With Fund support, the group partnered with the Centers for Medicare and Medicaid Services (CMS) to sponsor a symposium, "Creating Home," in Washington D.C. in April 2008. The meeting, which addressed how nursing homes' physical environments can support person-centered care, led to CMS's issuance of new interpretive guidance for industry regulators that is aimed at promoting culture change.

The Commonwealth Fund 2007 National Survey of Nursing Homes. Recently, the survey research firm Harris Interactive was asked by The Commonwealth Fund to assess the spread of culture change within the U.S. nursing home industry. According to the random national survey of nursing directors, many nursing homes are aware of the culture change movement and may be using some resident-centered practices associated with culture change, such as letting residents make decisions affecting their daily activities. Still, progress has been slow in transforming long-term care

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facilities from institutions to homes, and clearly much more work lies ahead. Findings from the survey were published in the May 2008 Fund report, *Culture Change in Nursing Homes: How Far Have We Come?*

Medicaid Coverage for Assisted Living. A significant number of frail elders insured by Medicaid can choose to live in an assisted-living facility, as an alternative to a nursing home. To gauge the effect that states' policies and programs have on Medicaid beneficiaries' eligibility for assisted-living services and on their access to providers, Eric Carlson, J.D., of the National Senior Citizens Law Center recently conducted a study of the 41 states whose Medicaid programs cover such services. In addition, five states—Arizona, New Jersey, Texas, Oregon, and Washington—were selected for closer study. Results are being shared with state legislators and Medicaid officials, as well as consumers, to promote the development of policies ensuring that frail elders who opt for assisted-living enjoy easy access to quality services.

Assessing State Investments in Culture Change. Because Medicaid pays for nearly half of all nursing home care, and because state survey agencies annually inspect nursing homes, there are many ways that states can motivate facilities to become providers of person-centered care. In her research, Robyn I. Stone, Dr.P.H., who is based at the American Association of Homes and Services for the Aging, investigated ways in which state policies and other actions can promote effective culture change. States that have invested significantly in culture change activities have focused on one or more of three strategic objectives: expanding person-centered care, promoting workforce development, and building nursing home capacity to engage in continuous quality improvement.

Stone says that federal and state regulations of nursing homes can be an obstacle to change if caregivers and home operators see surveyors—who visit homes to make sure they are complying with standards—as the enemy. In a Commonwealth Fund issue brief, she and her colleagues call for a new model of nursing home regulation that strikes a balance between the current regulatory process—which will still be needed to weed out substandard facilities—and a partnership model aimed at promoting high performance.

"The success of the partnership approach will depend, in large part, on the extent to which stakeholders buy into the process and assume responsibility for successful implementation," Stone says.

A Commonwealth Fund podcast explores the partnerships that both CMS and the Kansas Department on Aging have established. At CMS, meetings between regulators and providers have led to changes in the interpretive guidance provided to surveyors that consider residents' rights, the physical environment, and other quality-of-life issues in a new light. In Kansas, a new division has created grants for education and awards for home that deliver person-centered care.

Based on their findings, Stone and colleagues produced the *State Investment in Culture Change Toolkit,* available online from the American Association of Homes and Services for the Aging, which is designed to help states initiate or expand upon their culture change activities.

Resident-Centered Regulation. With support from both CMS and The Commonwealth Fund, the Rhode Island Department of Health conducted a pilot project centered on promoting individualized care in nursing homes. Focusing on the mandated federal regulatory survey process, the project sought to motivate and enable the state's nursing homes to realize the full potential for resident-centered care inherent in the 1987 Nursing Home Reform Law. The Individualized Care Pilot Toolbox, available on the Rhode Island Department of Health's Web site, provides survey teams with training materials that help them address common decisional dilemmas.

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Future Directions

In the coming year, the Fund's Program on Quality of Care for Frail Elders will continue to support the Advancing Excellence campaign by enhancing the capacity of local area networks to work with the facilities in their states to maintain improvement trends. It will also help implement a new communications plan and work with several state networks to pilot-test a way to preserve "critical access nursing homes"—those serving a primarily low-income, minority population—as a means to reduce disparities in nursing home care.

In addition, researchers at the University of Pennsylvania's Wharton School will be completing an assessment of the business case for nursing home adoption of electronic health record systems. That study is a companion piece to a comprehensive Fund-supported evaluation of a large-scale demonstration project in New York State looking at the impact of a health IT system on nursing home staff, resident outcomes, and organizational practices. And the Pioneer Network is being funded to continue its work with CMS and other stakeholder groups to promote a systems-based approach to transforming the field of nursing home care.

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The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy 2009–2010 Fellows

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The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy 2009–2010 Fellows

Program Goals

Moving toward a high-performance health care system requires trained, dedicated physician leaders who can promote policies and practices that improve minority Americans' access to high-quality care. Since 1996, the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy has played an important role in developing such leaders.

Based at Harvard Medical School under the direction of Joan Reede, M.D., M.P.H., M.S., M.B.A., the dean for diversity and community partnership, the year-long Minority Health Policy Fellowship offers intensive study in health policy, public health, and management. Fellows also participate in leadership forums and seminars with nationally recognized leaders in minority health and public policy. Under the program, fellows complete academic work leading to a master of public health degree at the Harvard School of Public Health.

Joan Reede, M.D., M.P.H., M.S., M.B.A.

As of the spring of 2009, 67 Fund fellows have graduated since the program began. In 2010–11, the Fund is supporting four Minority Health Policy Fellows and cofunding an additional two fellows in conjunction with Harvard University and the federal Health Resources and Services Administration; a seventh fellow is being supported by the California Endowment.

For more information, visit the Minority Health Policy Fellowship page at www.commonwealthfund.org or download the program brochure.

2009–10 Minority Health Policy Fellows

Jaya Aysola, M.D., D.T.M.H., Medical Director, The New Orleans Children's Health Project, and Section Chief, Community Pediatrics and Global Health, Department of Pediatrics, New Orleans, La.

Dr. Aysola was most recently the medical director of the New Orleans Children's Health Project and assistant professor in pediatrics and internal medicine at Tulane University School of Medicine. In addition, she was the section chief of Community Pediatrics and Global Health. In 2008, she received the Tulane Faculty Excellence in Teaching Award from the Department of Pediatrics. Her move to New Orleans came in response to Hurricane Katrina and her strong desire to assist in the recovery process. Initially, she provided pediatric and adult care to communities devastated by the storm, through a program funded by the Children's Health Fund. Since 2006, she has transitioned the program from urgent care to primary care pediatrics and comprehensive mental health care. Responding to the growing Hispanic migrant population, in 2008 she applied for and received a grant from Baptist Community Ministries for a Hispanic Outreach Initiative to provide the project's existing services in Spanish. Under her leadership, the program expanded to include a health education and disease prevention program designed to promote wellness in the community. In January 2009, she created the Section of Community Pediatrics and Global Health, dedicated to resident training in tackling the challenges of health care disparities domestically and abroad.

Dr. Aysola received her medical degree from the University of Pittsburgh School of Medicine in 2000 and completed her residency in both Internal Medicine and Pediatrics at William Beaumont Hospital–Royal Oak, Michigan, in 2004.

Lyle Ignace, M.D., Chief of Internal Medicine, Navajo Service Unit, Gallup Indian Medical Center, Gallup, N.M.

A member of the Coeur D'Alene Tribe of Idaho, Dr. Ignace is currently the chief of internal medicine, Navajo Service Unit, at the Gallup Indian Medical Center (GIMC) in Gallup, New Mexico. He is a public health service civil servant in the Department of Health and Human Services, Indian Health Service. A longstanding member of the Association of American Indian Physicians, he served on their executive board from 2000 to 2003 and again from 2007 to 2008. He is also the principal clinical investigator for GIMC's Chronic Care Initiative, a collaborative effort between the Institute of Healthcare Improvement and the Indian Health Service to develop and implement a chronic care model that is designed to improve health care management and promote disease prevention for all Native Americans.

Dr. Ignace received his medical degree from the University of Minnesota School of Medicine in 1996 and completed his Internal Medicine residency at the Medical College of Wisconsin at Milwaukee in 1999.

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Kamilah Jackson, M.D., Child and Adolescent Psychiatry Fellow, Yale Child Study Center, New Haven, Conn.

Dr. Jackson is a Child and Adolescent Fellow and the John Schowalter Chief Resident at the Yale Child Study Center in New Haven, Connecticut. She is also an Edward Zigler Fellow in Child Development and Social Policy for the 2008–2009 academic year. Her work at the faith-based community health center Full Circle Health, in Bronx, New York, was aimed at reducing the stigma surrounding mental illness in a predominantly African-American and Latino population. This experience led her to the Community Outreach Service Program, where she worked as the outreach team psychiatric consultant. Currently, she is working with the Intensive In-Home Child and Adolescent Psychiatric Service Program as a psychiatric consultant to a team that provides in-home services for substance-abusing mothers of children who have been identified as "at risk" by the state's department of children and families. She also is interested in the development of child and adolescent mental health services in the Caribbean.

Dr. Jackson received her medical degree from Columbia University College of Physicians and Surgeons in 2004 and completed her residency in Adult Psychiatry at the Emory University School of Medicine in 2007. She became a Diplomate of the American Board of Psychiatry and Neurology in April 2009.

E. Elon Joffre, D.M.D., Orthodontist, Malden, Mass.

Dr. Joffre is an orthodontist whose focus is on providing care to children in underserved and underprivileged communities. A native of Nassau, Bahamas, he has consistently practiced dentistry with low-income, underserved populations both locally and internationally. As a result of his commitment, he received the American Association of Public Health Dentistry dental student recognition award for achievement in community dentistry and dental public health in 2005. Dr. Joffre has a specific interest in improving access to orthodontic care. His goal is to develop programs and policies that will increase the number of underprivileged children who receive orthodontic treatment. Dr. Joffre received a D.M.D. from Tufts University School of Dental Medicine in 2005. He completed the Brigham and Women's Hospital/Harvard–Wide General Practice Residency in 2006. He then returned to Tufts where he completed his orthodontic certificate in June of 2008.

Alden Landry, M.D., Resident Physician, Harvard Affiliated Emergency Medicine Residency Program, Beth Israel Deaconess Medical Center, Boston, Mass.

Dr. Landry has most recently completed his final year of residency in the Harvard Affiliated Emergency Medicine Residency Program at Beth Israel Deaconess Medical Center (BIDMC) in Boston. During the two years he served as chair of the Diversity Committee, Dr. Landry developed the Medical Student Lecture Series for local medical students, recruited potential residents at various regional and national conferences, organized health education workshops in conjunction with Community Outreach office at BIDMC, guest-lectured to premedical student organizations at multiple colleges throughout the Boston area, and worked in conjunction with Visiting Clerkship Program of Harvard Medical School to mentor medical students. An instructor to the Protective Services Detachment of the 10th Mountain Division, U.S. Army, he also has collaborated with Massachusetts State Police Special Operations Officers to train 15 combat medics prior to deployment to Iraq by conducting high-fidelity, live-fire simulation medical training in Fort Devens, Massachusetts.

Dr. Landry received his medical degree from the University of Alabama School of Medicine in 2006, and completed his residency in Emergency Medicine at Beth Israel Deaconess Medical Center in Boston in June 2009.

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Susan Saucedo, M.D., Staff Physician, University Muslim Medical Association Community Clinic, Los Angeles, Calif.

Dr. Saucedo is currently a staff physician at the University Muslim Medical Association Community Clinic in Los Angeles, as well as a part-time staff physician in Kaiser Permanente in Los Angeles. Prior to that, she was a substitute teacher for grades K–8 in the Lennox School District. She continues to mentor students and has given lectures at numerous schools including the Hawthorne Academy of Math and Science High School and Ascot Elementary School. She has gained leadership experience through her volunteer efforts in Tanzania, Costa Rica, and Mexico. Dr. Saucedo has been honored with the Latino Medical Student Association Commitment to the Community Awards in 2003 and 2004, a National Medical Fellowship Scholar from 2000 to 2002, and a California Community Service Scholar in 2003. She was also a Robert Wood Johnson Minority Medical Education Program Scholar in 1997.

Dr. Saucedo received her medical degree from the David Geffen School of Medicine at the University of California, Los Angeles, in 2004. She completed her residency in Family Medicine at the Kaiser Permanente Los Angeles Family Medicine Residency Program in 2007 and a Family Medicine Faculty Development Fellowship at Harbor–UCLA Medical Center, Torrance, California, in 2008.

For more information on the

Minority Health Policy Fellowship

visit www.commonwealthfund.org
or download the program brochure.

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

1 East 75th Street
New York, NY 10021
Tel: 212.606.3800

1150 17th Street NW
Suite 600
Washington, DC 20036
Tel: 202.292.6700

International Program in Health Policy and Practice

THE COMMONWEALTH FUND

A Private Foundation Working Toward a High Performance Health System

Program Goals

As a nation that spends more on health care than any other and yet receives less in return than most, the United States can learn a great deal from the experiences of other countries in providing health insurance coverage and delivering cost-effective, timely, high-quality health care. To promote cross-national learning, the Commonwealth Fund's International Program in Health Policy and Practice aims to:

- build an international network of health care researchers devoted to policy;
- encourage comparative research and collaboration among industrialized nations; and
- spark creative thinking about health policy through international exchanges.

The program is led by Vice President
Robin Osborn, M.B.A.

The program's key activities include high-level international policy forums, the Harkness Fellowships in Health Care Policy and Practice, and an annual international survey on health policy issues.

Recent Projects

2008 International Symposium on Health Care Policy. For the past 11 years, the Fund has hosted an annual international health care policy symposium. The 2008 symposium, held in November in Washington, D.C., brought together nearly 100 policy experts around the theme, "Towards a High Performance Health Care System: Best Practices for Achieving Access to Care and Value for Money." Participants included health ministers or their designates from Australia, Canada, France, Germany, the Netherlands, New Zealand, Switzerland, the United Kingdom, and the United States, as well as senior government officials and leading researchers from each country.

A highlight of the symposium was the presentation of findings from the 2008 International Health Policy Survey, the 11th in a series of cross-national surveys, by Senior Vice President Cathy Schoen and Robin Osborn. The survey compared the health care experiences of adults with health problems in Australia, Canada, France, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States. The survey results, which were published as a Health Affairs Web Exclusive, showed major differences in health care access, safety, and efficiency, with U.S. patients at particularly high risk of forgoing care because of costs and experiencing errors or inefficient, poorly organized care.

A policy roundtable discussion among the health ministers at the symposium provided the opportunity for an exchange of views on what defines a high performance health care system and how to strike the right balance between health care quality, efficiency, innovation, and health system sustainability.

International Working Group on Quality Indicators. In 2004, the Fund's International Working Group on Quality Indicators produced the first-ever set of quality-of-care indicators—30 in all—for benchmarking and comparing health care system performance across countries. In collaboration with the Fund, the Organization for Economic Cooperation and Development (OECD) is building on this work through its International Healthcare Quality Indicators Project. The project, which includes 23 countries, is chaired by Harvard School of Public Health's Arnold Epstein, M.D., who previously chaired the Fund's working group.

The OECD project's first report, published in March 2006, included comparative data on 14 quality indicators in the 23 countries. The OECD continues to develop the scope and depth of the indicator set, and had produced 50 internationally comparable quality measures by late 2007.

Harkness Fellowships in Health Care Policy and Practice. Aimed at developing promising health care policy researchers and practitioners in Australia, Germany, the Netherlands, New Zealand, Norway, Switzerland, and the U.K., the Harkness Fellowships provide a unique opportunity for individuals to spend up to 12 months in the U.S. conducting a policy-oriented research study, gaining firsthand exposure to managed care and other models of health care delivery, and working with leading health policy experts.

Many former fellows move into high-profile positions in their home countries. And Harkness alumni continue to generate important research based on their fellowship work. For example:

- Adam Oliver (U.K., 2005–06) published a case study of the reform of the Veterans Health Administration in the *Lancet.*
- Mark Exworthy (U.K., 2002–03) and colleagues compared U.S. and U.K. progress on reducing health inequalities in an article published in the *Milbank Quarterly.*
- New Zealand Fellow Marie Bismark (2004–05) coauthored studies on New Zealand's no-fault medical malpractice system that appeared in *Quality and Safety in Health Care* and *Health Affairs.*

Australian-American Health Policy Fellowship. The Australian-American Health Policy Fellowship, a "reverse" Harkness Fellowship program established in 2002, is designed to enable two mid-career U.S. policy researchers or practitioners to spend up to 10 months in Australia conducting research and gaining an understanding of Australian health policy issues relevant to the U.S. Chaired by Andrew Bindman, M.D., the selection committee met in November 2008 and selected the fifth round of fellows.

www.commonwealthfund.org

Future Directions

In the coming year, the program plans to host several Capitol Hill briefings on international health reforms, cosponsored by the Alliance for Health Reform. One such briefing in April 2008, "Private Financing and High-Level Functioning: Some International Approaches to Health Reform," was attended by more than 200 congressional staff, policymakers, and journalists. It highlighted innovative policy approaches being taken in the Netherlands and Germany to address universal health coverage.

Since 1999, the Fund and the Nuffield Trust have sponsored annual symposia that have brought together senior government officials, leading health researchers, and practitioners from the United States, the United Kingdom, and Australia for an exchange on quality improvement policies and strategies. The 10th conference in this series will explore the use of incentives and provider payment policies.

The 2010 International Health Policy Survey will assess public perceptions of health system performance and responsiveness in 11 countries. Conducted in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States, the study will explore access to care, cost, comparative effectiveness, and quality of care received. The analysis of results will focus on the extent to which variations reflect differences in each nation's system of care delivery and insurance coverage. Survey findings will be released at the Fund's 2010 International Symposium.

To apply for a grant from The Commonwealth Fund's

International Program in Health Policy and Practice,

visit Applicant and Grantee Resources.

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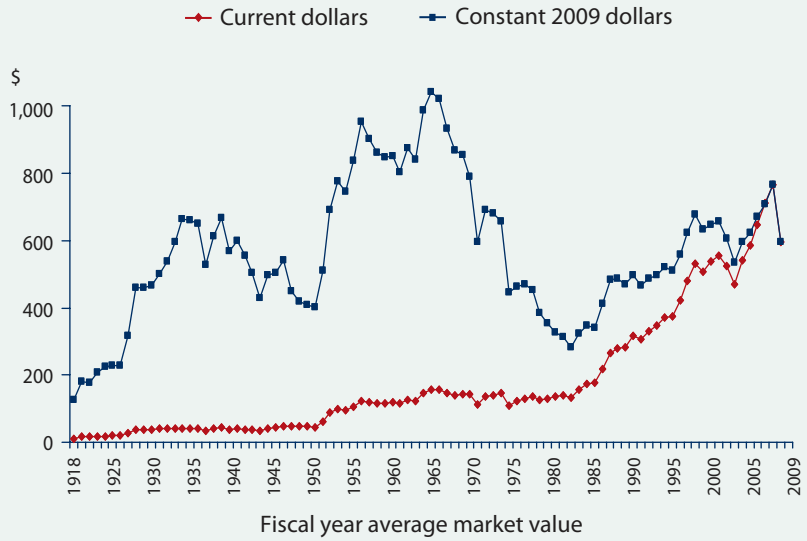
Treasurer's Report

John E. Craig, Jr.
The Commonwealth Fund 2009 Annual Report

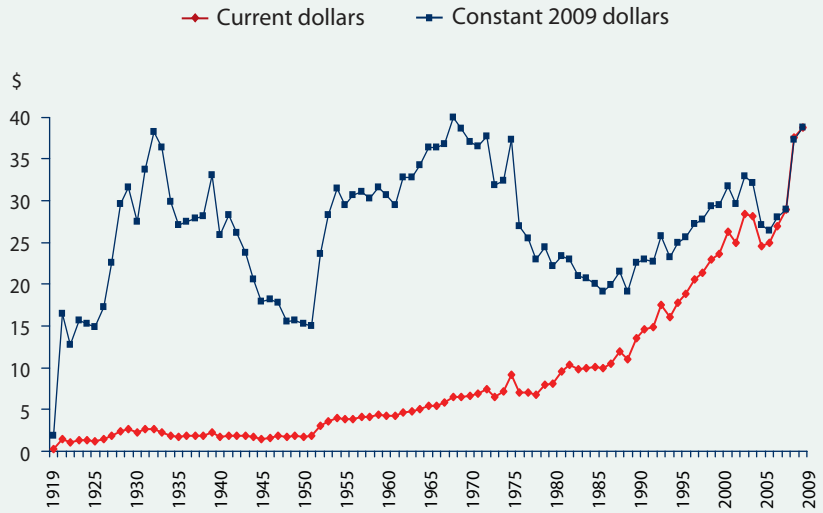
The Investment Committee of The Commonwealth Fund's Board of Directors is responsible for the effective and prudent investment of the endowment, a task essential to ensuring a stable source of funds for programs and the foundation's perpetuity. The committee determines the allocation of the endowment among asset classes and hires external managers, who do the actual investing. Day-to-day responsibility for the management of the endowment rests with the Fund's executive vice president and COO/treasurer, who with the assistance of consultants from Cambridge Associates, is also responsible for researching investment strategy questions to be addressed by the committee. The committee meets at least three times a year to:

- review the performance of the endowment and individual managers;
- reassess the allocation of the endowment among asset classes and managers and make changes as appropriate;
- deliberate investment issues affecting the management of the endowment; and
- consider new undertakings.

The Commonwealth Fund's endowment, in millions, 1918–2009



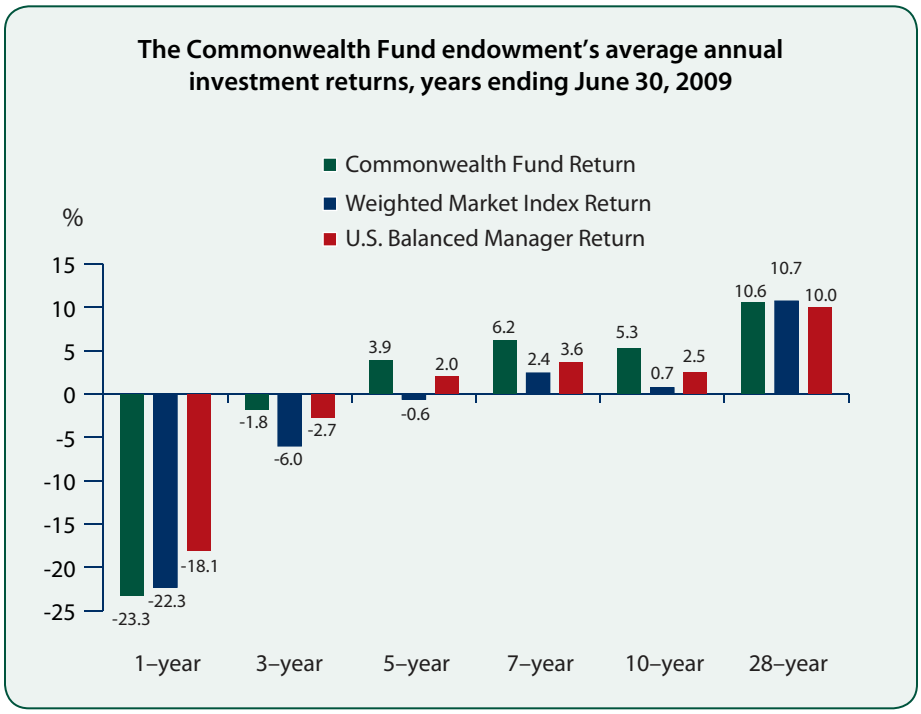
The Commonwealth Fund's annual spending, in millions, 1919–2009: Total spending of $806 million over 90 years, or $2.43 billion in constant 2009 dollars



The major global financial crisis and stock market crash of 2008–09 had a pronounced impact on The Commonwealth Fund's endowment, as it did on the endowments of virtually all U.S. foundations. Indeed, the relative order of magnitude of the fiscal year decline in the value of the endowment was equivalent, in the post–Great Depression era, only to market-value losses in the 1973–74 oil crisis. The value of the endowment fell from $752.1 million on June 30, 2008, to $549.8 million on June 30, 2009, reflecting a return of –23.3 percent on the investment portfolio during the year, combined with total spending (including programs, administration, investment management fees, and taxes) of $40.9 million. In that 12-month period, the return of the Wilshire 5000 index of U.S. stocks was –26.1 percent; the return of the Lehman Aggregate Bond index was 6.0 percent; and the return of a benchmark portfolio weighting these two broad market indexes according to the Fund's target allocations of stocks and bonds during the year was –22.3 percent. Uncharacteristically, the Fund's overall investment performance was below not only that of the weighted market benchmarks, but also the –18.1 percent produced by the median U.S. balanced manager during the fiscal year.

The Fund's team of equity (U.S. and international) managers produced a combined 12-month return of –27.3 percent, below the Wilshire 5000's –26.1 percent and the median U.S. equity manager's –25.8 percent. The foundation's substantial energy and commodities allocations played a significant role in producing its below-benchmark equities return, as did its emerging markets holdings. But the overall below-market return for the year was attributable primarily to the bond manager team's performance: –0.3 percent versus the benchmark's 6.0 percent—the result of significant investments in corporate debt securities and foreign debt and currencies at a time when, around the world, investors fled to the safety of U.S. government bonds.

As disappointing as the performance of the endowment was in 2008–09, its performance over longer periods remains competitive. As shown in the accompanying figure, the Fund's investment managers as a group outperformed the overall portfolio



market benchmark and the median balanced U.S. manager by wide margins over the three-, five-, seven- and 10-year periods ending June 30, 2009.

The salient features of the Fund's current investment strategy are summarized in the accompanying figure. Key among these are an overall target commitment of 88 percent of the portfolio to equities (publicly traded and private) and 12 percent to fixed-income securities; a 20 percent commitment to publicly traded U.S. equities, paired with a 20 percent commitment to international equities, including a 5 percent allocation to emerging markets; active large-capitalization-value-stock managers; assignment of responsibility for 20 percent of the endowment to marketable alternative equity (hedge fund) managers; a 10 percent commitment to non-marketable alternative equities (venture capital and private equities); and an 18 percent allocation to inflation hedges, including real estate, oil and gas, commodities, and TIPS.

The Fund board's Investment Committee has recently devoted particular attention to restructuring the management of the fixed-income portfolio. Aimed at preventing a repeat of the 2008–09 failure of the fixed-income portfolio to provide the expected protection in periods of financial markets crisis, the committee has reduced the extent to which it delegates to managers the responsibility for determining the allocation of the portfolio among different types of fixed-income securities. Excluding investment reserves held in cash equivalents, 38 percent of the fixed-income portfolio is now invested in a passive, U.S. government intermediate-term bond portfolio, and another 17 percent is similarly indexed, but with the manager employing a variety of strategies to increase returns by exploiting inefficiencies in fixed-income markets. The committee continues to employ a global fixed-income manager (21% of the fixed-income allocation) and, given the opportunities in distressed debt that resulted from the financial crisis, has opportunistically placed the remaining 24 percent of the fixed-income portfolio (3% of the total endowment) with a manager of this type.

The Investment Committee periodically reviews asset class allocation targets and the permissible ranges of variation around them. Except in very unusual circumstances, the portfolio is rebalanced when market forces or manager performance cause an allocation to diverge substantially from its target.

As a value-adding foundation, the Fund seeks to achieve an optimal balance between its grantmaking and intramural research and program management activities, while minimizing purely administrative costs. Recognizing that data on expenditures reported in the Internal Revenue Service 990PF annual tax return inadequately reflect the purpose of many expenditures, the analysis in the figure sorts out the foundation's 2008–09 expenditures according to four categories recommended by the Foundation Financial Officers Group: direct public-benefit activities (extramural grants and intramurally conducted programs, such as research, communications, and fellowships); grantmaking activities, including grants management; general and administrative activities; and intramural investment management. In 2008–09, the Fund's total direct public-benefit activities accounted for 84.5 percent of its annual expenditures. Value-adding oversight of grants took up 9.5 percent of the Fund's budget, and the intramural costs of managing the endowment, 1.0 percent. Appropriately defined, the Fund's administrative costs amounted to 5.0 percent of its budget.

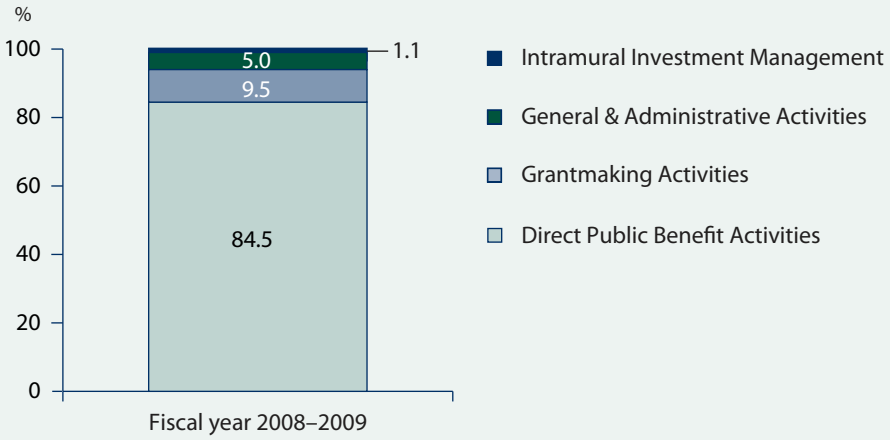
Three considerations determine the Fund's annual spending policy: the aim of providing a reliable flow of funds for programs; the objective of preserving the real (inflation-adjusted) value of the endowment and funds for programs; and the need to meet the IRS requirement of distributing at least 5 percent of the endowment for charitable purposes each year.

Like most other institutions whose sole source of income is their endowment, The Commonwealth Fund found it necessary to adjust spending plans to the new realities resulting from the 2008–09 financial

The Commonwealth Fund's endowment management strategy

	Allocation on June 30, 2009	Long-term target	Permissible range
Total endowment	100%	100%	
Asset Class			
Total Equity	79%	88%	75-90%
U.S. equity marketable securities	17%	20%	15-30%
Non-U.S. equity marketable securities	19%	20%	15-30%
Marketable alternative equity	14%	20%	0-20%
Non-marketable alternative equity	10%	10%	0-15%
Inflation hedges	19%	18%	5-20%
Fixed-Income Securities	21%	12%	10-20%

The Fund's total direct public benefit activities—including extramural grants and intramural research, communications, and programs conducted by the foundation—account for 85 percent of its annual expenditures. Value-adding oversight of grants takes up almost 10 percent of the Fund's budget.



markets crisis. The Board of Directors approved a 15 percent reduction in the Fund's budget for the 2009–10 fiscal year, lowering the total for that year to $34.7 million, from $40.9 million in 2008–09. To lower the spending rate to the long-term target of 5.4 percent of the endowment, further reductions in the Fund's budget are currently expected for the next four years: 10 percent in 2010–11, 6 percent in 2011–12, 2 percent in 2012–13, and 1 percent in 2013–14. Under this plan, the Fund's budget will be brought back to the $29 million level preceding the market bubble that led to the crash of 2008–09.

During the year, the Fund's board and management undertook a complete review of the foundation's budget to ensure that spending reductions are strategic and allocations of available funds are geared to program priorities. Fund staff have demonstrated creativity in achieving cost savings and reordering spending priorities in order to maximize the impact of the foundation's resources. As painful as the budget reductions have been, given still-subdued inflation, the Fund is fortunate that it continues to have the resources needed to maintain its role in informing health policy debates and promoting a high performance health system.

2009 Annual Report

Independent Auditors' Report

Financial Statements

Years Ended June 30, 2009 and 2008

2009 Annual Report

Independent Auditors' Report

The Commonwealth Fund

We have audited the accompanying statements of financial position of The Commonwealth Fund (the "Fund") as of June 30, 2009 and 2008 and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the Fund's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such financial statements present fairly, in all material respects, the financial position of the Fund at June 30, 2009 and 2008 and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Owen J. Flanagan & Co.
October 29, 2009

THE COMMONWEALTH FUND
STATEMENTS OF FINANCIAL POSITION
JUNE 30, 2009 AND 2008

	2009	2008
ASSETS		
CASH	$57,383	$328,107
INVESTMENTS - At fair value (Notes 1 and 2)	550,723,964	748,342,094
INTEREST AND DIVIDENDS RECEIVABLE	115,532	133,819
PROCEEDS RECEIVABLE FROM SECURITY SALES - NET	318,256	360,880
TAXES REFUNDABLE	1,813,852	1,009,149
PREPAID INSURANCE AND OTHER ASSETS		23,908
RECOVERABLE GRANTS		59,665
LANDMARK PROPERTY AT 1 EAST 75TH STREET -		
At appraised value during 1953, the date of donation	275,000	275,000
FURNITURE, EQUIPMENT AND BUILDING IMPROVEMENTS -		
At cost, net of accumulated depreciation of $ 1,562,304 at		
June 30, 2009 and $1,316,995 at June 30, 2008 (Note 1)	4,452,579	4,325,799
TOTAL ASSETS	$557,756,566	$754,858,421
LIABILITIES AND NET ASSETS		
LIABILITIES:		
Accounts payable and accrued expenses	$1,098,700	$1,123,751
Program authorizations payable (Note 3)	19,321,512	18,026,149
Accrued postretirement benefits (Note 4)	2,194,182	2,194,182
Deferred tax liability (Note 5)	454,039	2,953,974
Total liabilities	23,068,433	24,298,056
NET ASSETS:		
Unrestricted	534,688,133	730,560,365
Total net assets	534,688,133	730,560,365
TOTAL LIABILITIES AND NET ASSETS	$557,756,566	$754,858,421

See notes to financial statements.

THE COMMONWEALTH FUND
STATEMENTS OF ACTIVITIES
YEARS ENDED JUNE 30, 2009 AND 2008

	2009	2008
REVENUES AND SUPPORT:		
Interest and dividends	$8,559,797	$18,527,914
Contribution and other revenue	100,623	–
Total revenues and support	8,660,420	18,527,914
EXPENSES:		
Program authorizations and operating program	36,300,670	34,896,076
General administration	1,923,564	2,066,699
Investment management	4,064,044	4,872,386
Taxes (Note 5)	(2,453,030)	(378,796)
Unfunded retirement and other postretirement (Note 4)	225,365	75,298
Total expenses	40,060,613	41,531,663
EXCESS OF EXPENSES OVER REVENUES BEFORE NET INVESTMENT GAINS (LOSSES)	(31,400,193)	(23,003,749)
NET INVESTMENT GAINS (LOSSES):		
Net realized gains (losses) on investments	(39,475,243)	68,238,483
Change in unrealized appreciation of investments	(124,996,796)	(66,087,918)
Total net investment gains (losses)	(164,472,039)	2,150,565
CHANGES IN UNRESTRICTED NET ASSETS	(195,872,232)	(20,853,184)
Net assets, beginning of year	730,560,365	751,413,549
Net assets, end of year	$534,688,133	$730,560,365

See notes to financial statements.

THE COMMONWEALTH FUND
STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2009 AND 2008

	2009	2008
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets:	$(195,872,232)	$(20,853,184)
Net investment (gains) losses	164,472,039	(2,150,565)
Depreciation expense and retirement of assets	331,384	248,897
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Decrease in interest and dividends receivable	18,287	29,929
(Increase) in taxes refundable - net	(804,703)	(1,009,149)
Decrease in proceeds receivable from securities sales – net	42,624	123,983
Decrease (increase) in prepaid insurance and other assets	23,908	(3,712)
Decrease in recoverable grants	59,665	27,226
Increase (decrease) in accounts payable and accrued expenses	(25,051)	(286,530)
Decrease in taxes payable - net	–	(181,201)
Increase in program authorizations payable	1,295,363	809,517
Increase (decrease) in deferred tax liability	(2,499,935)	(1,321,746)
Net cash used in operating activities	(32,958,651)	(24,566,535)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of furniture, equipment, and building improvements - net	(458,164)	(601,266)
Purchase of investments	(192,409,526)	(384,535,842)
Proceeds from the sale of investments	225,555,617	409,657,232
Net cash provided by investing activities	32,687,927	24,520,124
NET INCREASE (DECREASE) IN CASH	(270,724)	(46,411)
CASH, BEGINNING OF YEAR	328,107	374,518
CASH, END OF YEAR	$57,383	$328,107
SUPPLEMENTAL INFORMATION -		
Taxes paid: excise and unrelated business income	$800,000	$2,133,300

See ntotes to financial statements.

THE COMMONWEALTH FUND

Notes to Financial Statements

Years Ended June 30, 2009 and 2008

1. Summary of Significant Accounting Policies

The Commonwealth Fund (the "Fund") is a private foundation supporting independent research on health and social issues.

a. *Investments* - Investments in equity securities with readily determinable fair values and all investments in debt securities are carried at fair value, which approximates market value. Assets with limited marketability, such as alternative asset limited partnerships, are stated at the Fund's equity interest in the underlying net assets of the partnerships, which are stated at fair value as reported by the partnerships. Realized gains and losses on dispositions of investments are determined on the following bases: FIFO for actively managed equity and fixed income, average cost for commingled mutual funds, and specific identification basis for alternative assets.

In accordance with Financial Accounting Standards Board Statement No.133, *Accounting for Derivative Instruments and Hedging Activities,* the Fund records derivative instruments in the statements of financial position at their fair value, with changes in fair value being recorded in the statement of activities. The Fund does not hold or issue financial instruments, including derivatives, for trading purposes. Both realized and unrealized gains and losses are recognized in the statements of activities.

b. *Fixed Assets* - Furniture, equipment, and building improvements are capitalized at cost and depreciated using the straight-line method over their estimated useful lives.

c. *Contributions, Promises to Give, and Net Assets Classifications* - Contributions received and made, including unconditional promises to give, are recognized in the period incurred. The Fund reports contributions as restricted if received with a donor stipulation that limits the use of the donated assets. Unconditional promises to give for future periods are presented as program authorizations payable on the statement of financial position at fair values, which includes a discount for present value.

d. *Use of Estimates* - The preparation of financial statements in conformity with generally accepted accounting principles requires the Fund's management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of additions to and deductions from the statement of activities. The calculation of the present value of program authorizations payable, present value of accumulated postretirement benefits, deferred Federal excise taxes and the depreciable lives of fixed assets requires the significant use of estimates. Actual results could differ from those estimates.

e. *Cash* - Cash consists of all checking accounts and petty cash.

At times the Fund's cash exceeds federally insured limits. This risk is managed by using only large, established financial institutions.

2. Investments

Investments at June 30, 2009 and 2008 comprised the following:

	2009		2008	
	Fair Value	**Cost**	**Fair Value**	**Cost**
U.S. Equities	$85,442,087	$99,162,268	$118,064,399	$130,831,825
Non - U.S. Equities	107,737,667	96,747,215	163,647,060	129,060,300
Fixed income	94,977,480	88,848,667	113,058,535	102,600,613
Short-term	8,709,505	8,856,065	13,108,097	13,108,097
Marketable alternative equity	107,017,384	70,265,832	121,695,638	70,284,736
Nonmarketable alternative equity	53,148,235	63,393,994	60,307,360	55,055,506
Inflation hedge	93,691,606	100,747,993	158,461,005	99,702,330
	$550,723,964	$528,022,034	$748,342,094	$600,643,407

At June 30, 2009, the Fund had total unexpended commitments of approximately $88.6 million in various nonmarketable alternative equity investments.

The Fund's investment managers may use futures contracts to manage asset allocation and to adjust the duration of the fixed income portfolio. In addition, investment managers may use foreign exchange forward contracts to minimize the exposure of certain Fund investments to adverse fluctuations in the financial and currency markets. At June 30, 2009 and 2008, the Fund had no outstanding derivative positions.

The Fund adopted FASB Statement No. 157, *Fair Value Measurements* (referred to as "Statement of Financial Accounting Standards 157" or "SFAS 157" for short), as of July 1, 2008. SFAS 157 defines fair value, establishes a framework for measuring fair value, and expands disclosures about fair value measurements.

Fair value of an investment is the amount that would be received to sell the investment in an orderly transaction between market participants at the measurement date.

SFAS 157 establishes a hierarchal disclosure framework which prioritizes and ranks the level of market price observability used in measuring investments at fair value. Market price observability is impacted by a number of factors, including type of investment and the characteristics specific to the investment. Investments with readily available active quoted prices or for which fair value can be measured from actively quoted prices generally will have a higher degree of market price observability and a lesser degree of judgment used in measuring fair value.

Investments measured and reported at fair value are classified and disclosed in one of the following categories.

Level 1 Inputs – Quoted prices in active markets for identical investments. In the case of funds, a reported NAV and full liquidity.

Level 2 Inputs – Other significant observable inputs (including quoted prices for similar investments, interest rates, etc). Hedge funds with reported NAV are included in this category.

Level 3 Inputs – Prices determined using significant unobservable inputs. Unobservable inputs reflect the Fund's own assumptions about the factors market participants would use in pricing an investment and would be based on the best information available. Investments included in this category generally include private equity, venture capital, real estate, natural resources, gas and oil, and hedge fund investments with limited liquidity.

In certain cases, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, an investment's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement.

Investments are categorized as follows:

	2009			
	Total	**Level 1**	**Level 2**	**Level 3**
U.S. Equities	$85,442,087	$85,442,087		
Non - U.S. Equities	107,737,667	107,737,667		
Fixed income	94,977,480	75,607,046	$19,370,434	
Short-term	8,709,505	8,709,505		
Marketable alternative equity	107,017,384	8,222,153	98,711,013	$84,218
Nonmarketable alternative equity	53,148,235			53,148,235
Inflation hedge	93,691,606	64,605,178	-	29,086,428
	$550,723,964	$350,323,636	$118,081,447	$82,318,881

	2008			
	Total	**Level 1**	**Level 2**	**Level 3**
U.S. Equities	$118,064,399	$118,064,399		
Non - U.S. Equities	163,647,060	163,647,060		
Fixed income	113,058,535	92,880,691	$20,177,844	
Short-term	13,108,097	13,108,097		
Marketable alternative equity	121,695,638	14,920,603	106,675,276	$99,759
Nonmarketable alternative equity	60,307,360			60,307,360
Inflation hedge	158,461,005	121,667,196	-	36,793,809
	$748,342,094	$524,288,046	$126,853,120	$97,200,928

The change in Level 3 investments is as follows:

Balance, July 1, 2008	$ 97,200,928
Purchases, redemptions etc.	15,276,218
Investment performance	(29,958,285)
Balance, June 30, 2009	$ 82,318,881

3. Program Authorizations Payable

At June 30, 2009, program authorizations scheduled for payment at later dates were as follows:

July 1, 2009 through June 30, 2010	$15,561,776
July 1, 2010 through June 30, 2011	3,695,922
Thereafter	194,522
Gross program authorizations scheduled for payment at a later date	19,452,220
Less adjustment to present value	130,708
Program authorizations payable	$19,321,512

A discount rate of 3.53 % was used to determine the present value of the program authorizations payable at June 30, 2009.

4. Unfunded Retirement and Other Postretirement Benefits

The Fund has a noncontributory defined contribution retirement plan, covering all employees, under arrangements with Teachers Insurance and Annuity Association of America and College Retirement Equities Fund and Fidelity Investments. This plan provides for purchases of annuities and/or mutual funds for employees. The Fund's contributions approximated 16% and 17% of the participants' compensation for the years ended June 30, 2009 and 2008. Pension expense under this plan was approximately $1,082,000 and $951,000 for the years ended June 30, 2009 and 2008, respectively. In addition, the plan allows employees to make voluntary tax-deferred purchases of these same annuities and/or mutual funds within the legal limits provided for under Federal law.

The Fund also has a group of former employees who retired prior to the inauguration of the above plan and certain other former employees to whom pension benefits have been approved, on an individual case basis, by the Board of Directors. Benefits under this program are paid directly by the Fund to these retirees. These pension payments approximated $71,000 for each of the years ended June 30, 2009 and 2008. In addition, the Fund provides health and life insurance to certain former employees.

Effective July 1, 2001, the Fund established a fully-funded Key Employee Stock Option Plan ("KEYSOP") for certain key executives which exchanges deferred compensation benefits for options to

purchase mutual funds. In addition, the KEYSOP awarded options to purchase mutual funds to certain employees in exchange for certain pension benefits. The Fund no longer makes contributions to the KEYSOP.

Effective July 9, 2002, the Fund established a Section 457 Plan for certain employees that provides for unfunded benefits with employer contributions made within the legal limits provided for under Federal law.

The Fund provides postretirement medical insurance coverage for retirees who meet the eligibility criteria. The postretirement medical plan, which is measured as of the end of each fiscal year, is an unfunded plan, with 100% of the benefits paid by the Fund on a pay-as-you-go basis. Such payments approximated $103,000 and $121,000 for each of the years ended June 30, 2009 and 2008.

Expected contributions under the postretirement medical plan for the fiscal year ended June 30, 2010 are expected to be approximately $108,000. Additional required disclosure on the Fund's postretirement medical plan for the years ended June 30, 2009 and 2008 is as follows:

	2009	2008
Benefit obligation at June 30	$2,194,182	$2,194,182
Fair value of plan assets at June 30	–	–
Status - unfunded	2,194,182	2,194,182
Actuarial loss	–	–
Accrued benefit cost recognized	$2,194,182	$2,194,182
Net periodic expense	$102,759	$120,825
Employer contribution	$102,759	$120,825

Immaterial changes in the calculation are not recorded on an annual basis.

Significant assumptions related to postretirement benefits as of June 30 were as follows:

	2009	2008
Discount rate	4.51%	4.80%
Health care cost trend rates – Initial	7.3%	7.3%
Health care cost trend rates – Ultimate	7.1%	7.1%

At June 30, 2009, benefits expected to be paid in future years are approximately as follows:

Year ended June 30, 2010	$108,000
Year ended June 30, 2011	$116,000
Year ended June 30, 2012	$131,000
Year ended June 30, 2013	$173,000
Year ended June 30, 2014	$180,000
Five years ended June 30, 2019	$848,000

5. Tax Status

The Fund is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code, but is subject to a 1% or 2% (depending if certain criteria are met) Federal excise tax on net investment income. For the years ended June 30, 2009 and 2008, that excise tax rate was 1%. The Fund is also subject to Federal and state taxes on unrelated business income. In addition, the Fund records deferred Federal excise taxes, based upon expected excise tax rates, on the unrealized appreciation or depreciation of investments being reported for financial reporting purposes in different periods than for tax purposes.

The Fund is required to make certain minimum distributions in accordance with a formula specified by the Internal Revenue Service. For the year ended June 30, 2009, distributions approximating $9.1 million are required to be made by June 30, 2010 to satisfy the minimum requirements of approximately $28.5 million for the year ended June 30, 2009.

In the Statements of Financial Position, the deferred tax liability of $454,039 and $2,953,974 at June 30, 2009 and 2008, respectively, resulted from expected Federal excise taxes on unrealized appreciation of investments.

For the years ended June 30, 2009 and 2008, the tax provision was as follows:

	2009	2008
Excise taxes - current	$46,905	$869,980
Excise taxes - deferred	(2,499,935)	(1,321,746)
Unrelated business income taxes - current	–	72,970
Total Taxes	$(2,453,030)	$(378,796)

6. Fair Value Of Financial Instruments

The estimated fair value amounts have been determined by the Fund, using available market information and appropriate valuation methodologies. However, considerable judgment is necessarily required in interpreting market data to develop the estimates of fair value. Accordingly, the estimates presented herein are not necessarily indicative of the amounts that the Fund could realize in a current market exchange. The use of different market assumptions and/or estimation methodologies may have a material effect on the estimated fair value amounts.

All Financial Instruments Other Than Investments - The carrying amounts of these items are a reasonable estimate of their fair value.

Investments - For marketable securities held as investments, fair value equals quoted market price, if available. If a quoted market price is not available, fair value is estimated using quoted market price for similar securities. For alternative asset limited partnerships held as investments, fair value is estimated using private valuations of the securities or properties held in these partnerships. The carrying amount of these items is a reasonable estimate of their fair value. For futures and foreign exchange forward contracts, the fair value equals the quoted market price.

7. Contributions Received

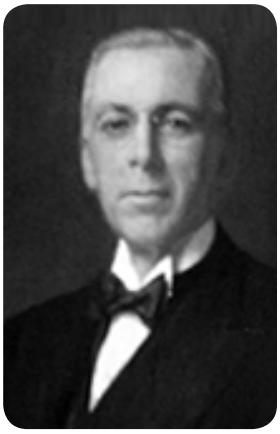
In fiscal years 1987 and 1988, the Fund received a total of $15,415,804 as a grant from the James Picker Foundation, with an agreement that a designated portion of the Fund's grants be identified as "Picker Program Grants by the Commonwealth Fund." The Fund fulfills this obligation by making Picker Program Grants devoted to specific themes approved by the Fund's Board of Directors. For the years ended June 30, 2009 and 2008, Picker program grants totaled approximately $1,802,000 and $1,902,000, respectively.

In April 1996, the Fund received The Health Services Improvement Fund, Inc.'s ("HSIF") assets and liabilities, $1,721,016 and $57,198, respectively, resulting in a $1,663,818 increase in net assets. In accordance with the terms of an agreement with HSIF, this contribution enables the Fund to make Commonwealth Fund/HSIF grants to improve health care coverage, access, and quality in the New York City greater metropolitan region. During the year ended June 30, 2009, a grant in the amount of $300,000 was awarded.

During the year ended June 30, 2002, the Fund received a bequest of $3,001,124 from the estate of Professor Frances Cooke Macgregor as a contribution to the general endowment, with the amount of annual grants generated by this addition to the endowment to be governed by the Fund's overall annual payout policies. An additional amount of $100,000 was received during the year ended June 30, 2004. This gift was made with the provisions that in at least the five-year period following its receipt, grants made possible by it will be used to address iatrogenic medicine issues, and that grants made possible by

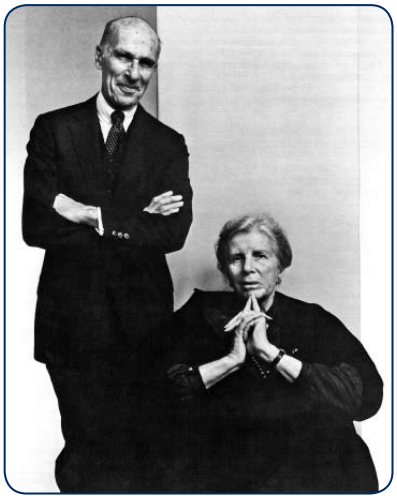
the gift be designated “Frances Cooke Macgregor” grants. During the years ended June 30, 2009 and 2008, the Frances Cooke Macgregor grants totaled approximately $372,000 and $299,000, respectively.

Founders and Benefactors



Anna Harkness and Edward Stephen Harkness

The story of The Commonwealth Fund begins with the family of Stephen V. Harkness, an Ohio businessman who began his career as an apprentice harnessmaker at the age of 15. His instinct and vision led him to invest in the early refining of petroleum and to make a further investment at a critical moment in the history of the fledgling Standard Oil Company. After her husband's death in 1888, Anna Harkness, Stephen's wife, moved her family to New York City, where she gave liberally to religious and welfare organizations and to the city's major cultural institutions. In 1918, she made an initial gift of nearly $10 million to establish a philanthropic enterprise with the mandate "to do something for the welfare of mankind," a broad and compelling challenge. Anna Harkness placed the gift in the wise hands of her son Edward Stephen Harkness, who shared her commitment to building a responsive and socially concerned philanthropy. During his 22 years as president of the foundation, Edward Harkness added generously to the Fund's endowment and led a talented and experienced staff to rethink old ways, experiment with fresh ideas, and take chances, a path encouraged by successive generations of leadership.



Jean and Harvey Picker

In 1986, Jean and Harvey Picker joined the $15 million assets of the James Picker Foundation with those of The Commonwealth Fund. James Picker, a prime contributor to the development of the American radiologic profession, had founded the Picker X-ray Corporation, an industry leader in its field. Recognizing the challenges faced by a small foundation, the Pickers chose the Fund as an institution with a common interest in improving health care and a record of effective grantmaking, management, and leadership. The Commonwealth Fund strives to do justice to the philosophy and standards of the Picker family by shaping programs that further the cause of good care and healthy lives for all Americans.

Directors and Staff

THE ROLE OF THE COMMONWEALTH FUND'S BOARD

Throughout its history and in keeping with its donors' intent, The Commonwealth Fund has sought to be a research-based catalyst for change by identifying promising practices and contributing to solutions that can help the United States achieve a high performance health system. The Fund's primary role has been to establish a base of scientific evidence demonstrating what works, to mobilize talented people to transform public and private health care groups, and to collaborate with individuals and organizations that share its concerns.

The Commonwealth Fund's Board of Directors has fiduciary responsibility for the foundation and is charged with ensuring its accountability and the effective pursuit of its mission. Throughout the foundation's history, the Board has been a policy-setting body, with responsibility for overseeing the overall mission, hiring and assessing the performance of the president/chief executive officer, advising on and approving program strategies, approving spending policy (including allocations of resources among programs and between extramural and intramural work, the Fund's annual budget, and Board-level grants), guiding the management of the Fund's endowment, and assessing the performance of the institution.

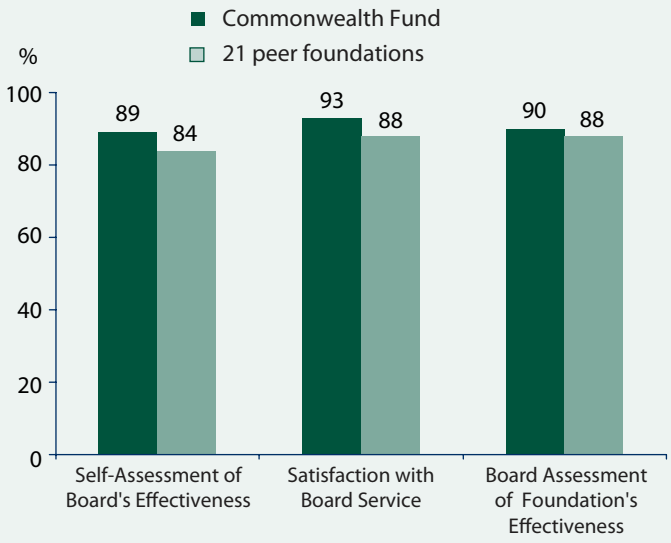
The Fund's Board also gives considerable attention to its own performance, for which the Board chair and the Governance and Nominating Committee have particular responsibility. Since 2003, Board members have participated in a confidential annual survey aimed at assessing their satisfaction with board service and ensuring continuing improvement in the Board's functioning and capacity to meet its fiduciary and oversight responsibilities. To enable benchmarking of the performance and satisfaction of the Fund's Board against that of peer foundations, the Fund since 2006 has participated in the annual Survey of Foundation Trustees conducted by the Center for Effective Philanthropy (CEP). The Fund is one of some 68 foundations now participating in the CEP survey, and it is the only foundation doing so annually.

As did earlier CEP reports, the 2009 survey revealed that Fund board members have a strong level of satisfaction with their service, with the Board's effectiveness, and with the performance and impact of the foundation. The survey indicated that the Fund is unusual in the degree to which its Board is engaged in assessing the foundation's performance. It also revealed interest in even more involvement in assessing the performance of programs and the foundation overall, and in helping shape program

strategy. In most respects, the Fund surpasses its peer foundations in measures of Board performance and satisfaction with service, as well as in the Board's assessment of the foundation's performance.

The Fund is fortunate in having Board members who are highly experienced on health care issues, deeply committed to the goal of a high performance health system, and willing to devote considerable time, energy, and thought to overseeing and guiding the foundation's activities.

The Commonwealth Fund's Board is deeply engaged in overseeing the foundation's activities.



Source: Center for Effective Philanthropy 2009 Foundation Trustee Survey.

Note: All listings are as of June 30, 2009. For current Fund directors and staff, as well as staff contact information, please visit commonwealthfund.org.

BOARD OF DIRECTORS

James R. Tallon, Jr., *Chair*
William R. Brody, M.D.
Benjamin K. Chu, M.D.
Karen Davis
Michael V. Drake, M.D.
Samuel C. Fleming
Glenn M. Hackbarth
Jane E. Henney, M.D.
James J. Mongan, M.D.
Robert C. Pozen
Cristine Russell, *Vice Chair*
William Y. Yun

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Lewis M. Branscomb
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Helene L. Kaplan
Margaret E. Mahoney
Walter E. Massey
William H. Moore
Robert M. O'Neil
Roswell B. Perkins
Charles A. Sanders, M.D.
Robert L. Sproull
Alfred R. Stern
Samuel O. Thier, M.D.
Blenda J. Wilson

Note: All listings are as of June 30, 2009. For current Fund staff and contact information, please visit commonwealthfund.org.

STAFF

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Karen Davis, *President*
Gary E. Reed, *Executive Assistant*
Kristof Stremikis, *Research Associate to the President*

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Jason St. Germain, *Grants Manager*
Leslie K. Knapp, *Financial Associate*
Jessalynn K. James, *Grants Associate*
Jordana Williams, *Executive Assistant*

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Tamara Ziccardi-Perez, *Director of Administration*
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Matthew E. Johnson, *Dining Room Manager*
Edwin A. Burke, *Assistant Dining Room Manager*
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Anne-Marie J. Audet, M.D., *Vice President, Health Care Quality Improvement and Efficiency*
Anne C. Beal, M.D., *Assistant Vice President, Eliminating Health Care Disparities*
Sara R. Collins, *Assistant Vice President, Future of Health Insurance*

Michelle M. Doty, *Director of Survey Research*

Anne K. Gauthier, *Assistant Vice President and Deputy, Director, Commission on a High Performance Health System*

Stuart Guterman, *Assistant Vice President*, Medicare's Future

Mary Jane Koren, M.D., *Assistant Vice President, Quality of Care for Frail Elders*

Douglas McCarthy, *Senior Research Advisor (Issues Research, Inc.)*

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Robin I. Osborn, *Vice President and Director, International Program in Health Policy and Practice*

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Maureen Angeles Deboo, *Executive Assistant*

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Ashley-Kay Fryer, *Program Assistant, Health Care Quality Improvement and Efficiency*

Allison S. Frey, *Associate, Commission on a High Performance Health System*

Gretchen W. Hagelow, *Program Associate, Child Development and Preventive Care*

Susan E. Hernandez, *Program Associate, Health Care Disparities*

Elizabeth K. Hodgman, *Program Assistant, Patient-Centered Primary Care Initiative*

Sabrina K. H. How, *Senior Research Associate, Commission on a High Performance Health System*

Claire Kiefer, *Program Assistant, Grants Management and Administration, International Program in Health Policy and Practice*

Leslie Kwan, *Program Assistant for Fellowships and Research, International Program in Health Policy and Practice*

Stephanie A. Mika, *Program Associate, Policy and State Innovations*

Jennifer Lara Nicholson, *Associate Program Officer, Future of Health Insurance*

Michelle G. Ries, *Program Associate, International Program in Health Policy and Practice*

Sheila D. Rustgi, *Program Assistant, Future of Health Insurance*

David Squires, *Program Associate for Research, International Program in Health Policy and Practice*

Communications Office

Barry A. Scholl, *Vice President for Communications and Publishing*

Christopher A. Hollander, *Director of Publications*

Christine F. Haran, *Director of Online Information*

Mary C. Mahon, *Senior Public Information Officer*

Paul D. Frame, *Production Editor*

Deborah L. Lorber, *Editor*

Suzanne Barker Augustyn, *Assistant Production Editor*

Ned C. Butikofer, *Web Production Associate*

Amanda J. Greep, *Communications Associate*

Martha Hostetter, *Editorial Advisor and Consulting Web Editor*

Staff completing their service during fiscal year 2008–09 are as follows:

Meghan Bishop, *Assistant Director, International Program in Health Policy and Practice*
Ingrid Caldwell, *Receptionist*
Jennifer Lau, *Program Associate, Quality Improvement and Efficiency*
Anthony Shih, M.D., *Assistant Vice President, Quality Improvement and Efficiency*
Elizabeth Sturla, *Research Associate*
Pamela Terry, *Program Assistant, International Program in Health Policy and Practice*

White & Case, *Counsel*
Owen J. Flanagan and Company, *Auditors*

The Commonwealth Fund

Grants Approved, 2008—09

Commission on a High Performance Health System

Commission Activities

Alliance for Health Reform
$333,878
Commission on a High Performance Health System: Meetings
Since July 2007, the Fund's Commission on a High Performance Health System has convened three times and issued its second national scorecard on health system performance; developed an agenda for the next presidential administration to reach and raise benchmark levels of performance; released a report examining 15 policy options that could save $1.5 billion in health expenditures over 10 years; issued an analysis of presidential candidates' health reform proposals; and produced papers on other key health system issues. In the coming months, the Commission will release a report on organizing the care delivery system and continue to develop other products and policy recommendations. Its work will also be reflected in current Fund-sponsored activities, including the Bipartisan Congressional Retreat, Congressional Staff Retreat, and Alliance for Health Reform briefings and roundtables. The Alliance is responsible for all logistical details for the Commission's three annual meetings to discuss current projects and future undertakings.
Edward F. Howard, J.D.
Executive Vice President
1444 Eye Street NW, Suite 910
Washington, DC 20005-6573
(202) 789-2300
edhoward@allhealth.org

Alliance for Health Reform
$382,758
Commonwealth Fund Bipartisan Congressional Retreat, 2009
The Fund's annual Bipartisan Congressional Retreat gives members of Congress the opportunity to learn about timely health policy issues and engage in substantive discussion, all in an environment free from partisan politics and media pressures. It is not only a direct way to reach the Fund's most influential audience, but it helps build working relationships with members of Congress who can advance the Fund's mission. The 2009 retreat will focus on the Commission on a High Performance Health System's recommendations for the new president and Congress, payment reform, public and private options for coverage expansions, and models for accountable and coordinated care. In the interest of improving both participation and post-meeting follow-up, the grant was expanded to cover special briefings for members of Congress, creation of a database of key contacts, and assistance in disseminating outreach materials.
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edhoward@allhealth.org

Alliance for Health Reform
$279,965
Health Policy Seminars and Congressional Staff Retreat, 2008-09
Alliance for Health Reform briefings are a valuable resource for congressional staff and journalists seeking the latest health policy information and analysis. In the coming year, the Alliance will conduct seven briefings or roundtables on such topics as: findings from the Fund's updated health system scorecards; options for national coverage expansions; the effect national health reform would have on state reform initiatives; getting physician buy-in for quality improvement; pay-for-performance and Medicare; long-term financing of Medicare Part A; containing costs without compromising quality; preparing for retiring baby boomers; and new findings on disparities in coverage and care. The Congressional Staff Retreat is a unique opportunity for up to 100 senior health staff from both political parties to engage in an informal, off-the-record exchange of ideas.
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edhoward@allhealth.org

The Commonwealth Fund
$90,000
Analytic Work for Developing and Updating the Commission Scorecards on Health System Performance
The Commission created the National and State Scorecards to assess U.S. and state health system performance across multiple dimensions of health outcomes, quality, access, efficiency, and equity. The next editions of the scorecards will update and analyze time trends to assess the nation's progress in closing performance gaps and state variations in care. This authorization will enable the Commission's research director to produce updated analyses of national data sources, Fund-supported surveys, and quality initiatives in support of both scorecards. Findings of this work will assist the Commission as it monitors system performance over time and assesses the impact of existing and proposed policies.

Cathy A. Schoen
Senior Vice President
One East 75th Street
New York, NY 10021
(212) 606-3864
cs@cmwf.org

Issues Research, Inc.
$316,770
Maintaining the National and State Scorecards and Developing Content for Case Studies, Newsletters, and Online Resources, 2009
The Commonwealth Fund seeks to stimulate higher performance across the U.S. care health system by educating health care providers, policymakers, and others about the nature and scope of performance deficits, the implications for the health and well-being of Americans, and promising approaches for addressing problems. The development and production of effective information resources is critical for advancing this educational process. This contract will engage the services of Issues Research, Inc., for a third year to provide research, writing, and advisory services in support of the national and state health system scorecards, case studies of high-performing organizations and other innovations, the new WhyNotTheBest.org Web site, the Fund's Quality Matters and States in Action newsletters, and related Fund publications and online tools.
Douglas McCarthy
President
1099 Main Street, Suite 305
Durango, CO 81301
(970) 259-7961
dmccarthy@issuesresearch.com

The Lewin Group, Inc.
$200,000
Path to High Performance: Informing a National Policy Agenda to Improve Outcomes and Slow Cost Growth
This project will build on efforts undertaken by the Commission on a High Performance Health System to identify strategic policies that could put the nation on a path to a well-functioning health care system. It will assess the potential of payment reforms and targeted investments in system innovation over the next 15 years, if combined with universal coverage and more efficient insurance arrangements. Fund staff will work with the Commission to develop a set of policy options that could be implemented as a package and enhanced over time to improve access to care, improve health outcomes, and slow growth in health expenditures. The options will focus on: 1) developing payment reforms that align incentives to support patient-centered, cost-effective, high-quality, integrated care; 2) generating evidence on the clinical and cost-effectiveness of care and improving population health; 3) fostering investment in information technology systems; and 4) expanding insurance coverage and promoting high-value benefit design.
John F. Sheils
Senior Vice President
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042
(703) 269-5610
john.sheils@lewin.com

Small Grants—Commission Activities

The Brookings Institution
$50,000
Medicare and Accountability-Based Payment Reform: Learning from Development and Implementation of the Medicare Health Care Quality Demonstration
Aaron McKethan, Ph.D.
Research Director
The Engleberg Center for Health Care Reform
1775 Massachusetts Avenue, NW
Washington, DC 20036-2188
(202) 797-6073
amckethan@brookings.edu

Health Management Associates, Inc.
$45,000
State Scorecard Profiles & Overview Report
Sharon Silow-Carroll
Principal
1133 Avenue of the Americas, Suite 2810
New York, NY 10036
(212) 575-5929
ssilowcarroll@healthmanagement.com

James Graham Atkinson
$10,000
Lessons from Hospital Rate-Setting
James Graham Atkinson, D.Phil.

Consultant
1449 44th Street, NW
Washington, DC 20007-2002
(202) 338-6867
jgatkinson@aol.com

March of Dimes Foundation
$25,000
Symposium on Quality Improvement to Prevent Prematurity: Action and Dissemination Plan
Alan R. Fleischman, M.D.
Senior Vice President and Medical Director
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 997-4649
afleischman@marchofdimes.com

National Academies of Practice
$5,000
Transforming Healthcare: Models of Accountable Interdisciplinary Care Coordination That Work
Mary E. Costanza, M.D.
President
University of Massachusetts Medical School
55 Lake Street North
Worcester, MA 01655
(508) 856-3902
mecost@comcast.net

Robinow Consulting
$50,000
The Voice of Experience: Lessons for Global Payment Models
Ann Robinow
President
5916 Lee Valley Road
Edina, MN 55439
(612) 963-5822
annrobinow@gmail.com

Program on the Future of Health Insurance

Analysis and Modeling of the Leading Health Care Reform Bills of the 111th Congress (2009-10)
This project will inform health reform policy by producing timely and targeted analyses, including microsimulation modeling.

Health Policy R&D
$250,000
Analysis and Modeling of the Leading Health Care Reform Bills of the 111th Congress (2009-10)
Katie B. Horton
President
1155 F Street, NW, Suite 700
Washington, DC 20004
(202) 508-6317
khorton@hprd.net

Presidential/Congressional Transition Year Opportunities
This appropriation for presidential/congressional transition year opportunities authorizes the Fund's president to underwrite such projects include modeling insurance tax credits or premium subsidies, modeling phase-in options for universal coverage, analyzing options for improving Medicare benefits, and identifying and modeling reform financing strategies.

Urban Institute
$64,334
Options for Changing the Employer Benefit Tax Exemption
Rosanne Altshuler, Ph.D.
Senior Fellow and Co-Director
Urban-Brookings Tax Policy Center
2100 M Street, NW
Washington, DC 20037
(202) 833-4388
raltshuler@urban.org

The Lewin Group, Inc.

$37,385
Updating Cost Estimates for the Path to High Performance and Medicare Extra
John F. Sheils
Senior Vice President
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042
(703) 269-5610
john.sheils@lewin.com

Brigham and Women's Hospital Inc
$186,366
Assessing the Impact of Lower Prescription Drug Cost-Sharing on Medication Adherence, Clinical Outcomes and Health Care Costs
Of the many factors that contribute to poor medication adherence among the chronically ill, the portion of drug costs borne by patients appears to be central. Pitney Bowes is one of a handful of large employers and insurers that have begun experimenting with reduced copays for essential medications. In 2007, the company reduced or eliminated cost-sharing for medications used to treat coronary artery disease and osteoporosis, with the goal of improving employees' medication adherence and health outcomes. This project will examine Pitney Bowes claims data to determine the impact that reduced copayments have had on medication adherence, clinical outcomes, health care utilization, and costs. The findings will aid employers, private insurers, the Medicare program, and policymakers in crafting changes to the structure of health benefits that lead to increased use of prescription drugs known to be effective for managing chronic disease.
Niteesh K. Choudhry, M.D., Ph.D.
Project Director
1620 Tremont Street, Suite 3030
Boston, MA 02120
(617) 287-0930
nchoudhry@partners.org

Trustees of Columbia University in the City of New York
$194,719
Contributing to Health Care Reform: Analysis and Technical Assistance
A Columbia University research team will conduct original analyses to inform policymakers about key issues in health insurance reformâ€”with specific topics dependent on the unfolding political, economic, and fiscal environments at the federal and state levels. They will also examine the relationship between the State Scorecard's health outcome measures and state variations in health policy, uninsured rates, physician supply, and economic conditions. As in the past, the Columbia team will provide programming, data, and analytic support for the Fund, the Commission on a High Performance Health System, and grantees.
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New York, NY 10032
(212) 305-0299

International Communications Research, Inc.
$266,744
Commonwealth Fund Survey of Young Adults
Updated each year since 2003, the Fund issue brief Rite of Passage? provides the latest information on insurance coverage of adults ages 19 to 29â€”one of the largest groups of Americans without health insurance. The annual publication, which has established the Fund as the go-to source of information on the issue, also recommends policy options for ensuring that more young adults have stable, quality coverage. Expanding upon this work, the project team will conduct a new survey of 2,000 young adults to investigate their attitudes toward health insurance, their experiences seeking insurance, their financial ability to secure coverage from available sources, the quality of coverage they now have, and their use of health services. The new survey will further the nation's understanding of the causes and implications of this coverage deficit and provide policymakers with concrete guidance on ways to help young adults obtain, and maintain, health insurance.
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mherrmann@icrsurvey.com

Princeton Survey Research Associates International
$485,270
The Commonwealth Fund Biennial Health Insurance Survey, 2009
Over the past decade, the Fund's biennial health insurance surveys have garnered a national reputation for providing an accurate portrayal of the state of health insurance coverage in the United States. In reports and journal articles based on data from the six surveys conducted since 1999, Fund staff have been able to assess the stability and quality of U.S. adults' health insurance coverage, their cost-related difficulties in getting needed care, and their problems paying medical bills. Fielded in the midst of a severe economic recession, the 2009 survey will yield key information about trends in employer-based coverage, including premiums and out-of-pocket costs, the number of adults with gaps in their insurance coverage, and changes in the number who are underinsured. It will also ask whether people have a medical home, whether they receive timely preventive care and chronic disease care, and whether their chronic conditions are under control.
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Principal and President

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Rand Corporation
$214,066
Implementing a National Insurance Connector
The high cost of individual insurance policies, and common underwriting practices that exclude many applicants with certain health conditions, has made these plans an inadequate substitute for group coverage. A number of legislators have proposed to address the problem by reorganizing and regulating the individual and smallâ€"group markets through the creation of diverse risk pools for individuals and small businesses. As part of its new universal coverage law, Massachusetts lawmakers created such a market-an insurance connector. This study will evaluate the issues involved in implementing a connector on the national level and how it could be designed to improve the accessibility and affordability of coverage, especially for the uninsured and underinsured. The project team also will consider strategies to adjust or equalize risk across plans to encourage insurers to compete on the basis of quality, rather than risk avoidance.
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Small Grants—Program on the Future of Health Insurance

Education & Research Fund of the Employee Benefit Research Institute
$46,000
Sustaining Membership in the EBRI/ERF: Support for the Annual Health Confidence and Consumer Engagement in Health Care Surveys, 2010
Paul Fronstin, Ph.D.
Director, Health Research and Education Program
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fronstin@ebri.org

Education & Research Fund of the Employee Benefit Research Institute
$46,000
Sustaining Membership in the EBRI/ERF: Support for the Annual Health Confidence Survey and the Consumer Engagement in Health Care Survey, 2009
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National Opinion Research Center
$39,972
Improving the Art of Estimating the Effects of Health Reform Legislation: Learning from Past Experience
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gabel-jon@norc.org

Urban Institute
$50,000
Insights for Health Reform from the New COBRA Subsidy Program
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Medicare's Future

Center for Health Care Strategies, Inc.

$215,157
Promoting Integrated Delivery Systems for Medicare's Most Vulnerable Beneficiaries
The complex and costly health care needs of Americans who are dually eligible for Medicare and Medicaid would be better addressed if there were more coordination across the two programs, but efforts to achieve this goal have been largely unsuccessful in the more than 40 years since they began. The Special Needs Plans available under Medicare Advantage provide one model for such coordination, but they have not lived up to their potential so far. For this project, researchers will work with the federal government, states, health plans, providers, and beneficiary groups to: 1) develop and implement approaches for improving the integration of care delivered to dually eligible beneficiaries; and 2) provide stakeholders with technical assistance, tools, and resources, focusing on mechanisms to improve alignment of what are frequently conflicting incentives between Medicare and Medicaid.
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The Commonwealth Fund
$400,000
Modeling the Impact of Changes to Medicare Payment Policy and Broader Payment Reforms
Achieving and sustaining a high performance health system will require changes in the way we pay for care, as well as incentives that encourage more appropriate, effective, and efficient care delivery. For this project, the Fund will select one or more organizations with the capacity to 1) model and analyze up to 15 policy options for reforming the way Medicare and other public and private insurers pay for care and 2) assess the impact of these reforms on payers, care providers, and patient populations. Based on these analyses, Fund staff, working with the grantee, will produce issue briefs and other publications to inform the debate over the best ways to slow the growth of public and private health spending while enhancing value.
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Health Research and Educational Trust>
$179,966
*Analyzing Medicareâ€™s Payment Policy for Hospital-Acquired Conditions and Its Impact on Safety-Net Hospitals*To improve quality of care for Medicare beneficiaries, the Centers for Medicare and Medicaid Services (CMS) has specified a list of eight avoidable hospital-acquired medical conditions that it soon will no longer consider in determining payment for inpatient hospital stays. Another nine conditions may be added to the list. This study will provide information about the potential impact of CMSâ€™s ""value-based purchasing"" policy on safety-net and other hospitals, and identify strategies that different types of hospitals are using to respond to the CMS incentives, reduce the incidence of hospital-acquired conditions, and develop quality improvement programs.
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University of Maryland, Baltimore
$493,844
Achieving Maximum Value from Prescription Drug Coverage of Chronically Ill Medicare Beneficiaries
This study tests the premise that through better management of medication regimens, the health of chronically ill Medicare beneficiaries will improve and this improvement, in turn, will lead to significantly reduced spending on traditional Medicare services. The first part of the project, which will focus on Medicare beneficiaries enrolled in employer-based retiree health plans, will estimate the potential savings from establishing optimal drug treatment regimens for five common chronic diseases. The second part will focus on service utilization and costs for beneficiaries enrolled in stand-alone Medicare Part D prescription drug plans. Armed with these findings, policymakers and health plan managers will be able to target quality improvement efforts and devise cost-sharing policies that maximize the value of prescription coverage for beneficiaries with chronic disease.
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Tufts Medical Center, Inc.
$244,902
Using Cost-Effectiveness Research to Improve Value in the Medicare Program

While Medicare and other health care spending continue to rise at a steady clip, there is mounting evidence that these ever-increasing expenditures are not producing better outcomes for patients. As a result, more attention is being paid to improving the effectiveness of the resources we use. This project will examine opportunities to improve the value obtained from Medicare spending. Drawing from the Medicare National Coverage Decisions Database and the Tufts Medical Center Cost Effectiveness Analysis registry, the investigators will: 1) identify ""low-value"" services (i.e., those whose cost is high relative to the outcomes they achieve) and services that could produce better outcomes more cost-effectively; and 2) develop estimates of the savings and improved outcomes that are possible from allocating Medicare resources more appropriately.
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Urban Institute
$219,809
Improving Medicare's Performance Through Reform of Its Benefit Structure and Provider Payment System
While Medicare has in general been successful in ensuring that its beneficiaries have access to affordable health care, the sickest and poorest beneficiaries often face financial burdens that threaten this access. Rapid growth in Medicare spending, meanwhile, has pressured the government to cut payments to providers. This project will pursue two sets of strategies for improving Medicare's ability to serve all its beneficiaries, and to do so more efficiently. First, the researchers will examine policy options for helping low-income beneficiaries access a more unified and comprehensive set of Medicare benefits. Second, they will develop and model the impact of approaches for improving the way Medicare pays physiciansâ€"to protect access to care while setting payments that better reflect the value of services.
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Small Grants—Medicare's Future

Council of Accountable Physician Practices
$25,357
Roundtable on Payment Reform
Nancy Taylor
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National Academy of Social Insurance
$5,000
Medicare Coverage for the Disabled: How Long Must They Wait? A NASI Conference Roundtable
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Health Care Quality Improvement and Efficiency

Brigham and Women's Hospital Inc
$371,856
Evaluating the Impact of Computerized Physician Order Entry Systems on the Quality, Safety and Cost of Care in Massachusetts Community Hospitals
Frances Cooke Macgregor Grant
Computerized physician order entry (CPOE) is one of the technologies at the forefront of efforts to enable health care organizations to provide better care more efficiently. Still, just one of 10 U.S. hospitals have adopted CPOE. Community hospitals, which account for most hospitalizations, face particular difficulties implementing the technology, owing to the substantial capital costs involved. This project will evaluate five community hospitals that recently implemented CPOE under the auspices of the Massachusetts Technology Collaborative. The evaluation will determine how CPOE use has affected quality of care and what savings have accrued to hospitals and payers. With nearly $20 billion allocated in the federal economic stimulus package toward health IT adoption, this study will identify optimal strategies to accelerate adoption of this promising physician tool.
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Group Health Cooperative
$403,929
Assessing the Impact of Patient Decision Aids on Health Care Utilization and the Costs of Care
Evidence suggests that by aligning medical treatment options more closely with the informed preferences of patients, we can encourage more appropriate use of services in the United States. Because they can help patients make informed choices, patient decision aidsâ€"evidence-based tools used to facilitate shared decision-makingâ€"hold promise to reduce unwarranted regional variations in treatment for preference-sensitive medical conditions. This project will evaluate the impact of implementation of patient decision aids throughout Group Health's extensive network of physician group practices in Washington State. Using a comparison group, the investigators will assess the differential effect of decision aids on the use of 12 elective surgical procedures, total health care utilization, and total costs.
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Group Health Cooperative
$350,688
Achieving Best Practices for Patient Referral
To coordinate patient care effectively, primary care providers must not only identify resources and make appropriate referrals, but they must also communicate with other service providers, help patients access specialty services, monitor the referral and consultation processes, and integrate findings from referrals into the care they provide. Studies have shown, however, that practices lack the tools and training to implement and maintain high-quality referral processes in coordinating patient care. Directed by a national leader in primary care practice improvement, this project will develop consensus standards for the provision of referral services and test strategies to change referral practice. One of the key products will be a training manual that state agencies, payers, and health care organizations can use to help primary care practices achieve high performance for this critical area of care.
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Health Management Associates, Inc.
$460,940
Case Studies of Innovation and High Performance for WhyNotTheBest.org
The Commonwealth Fund launched the Web site WhyNotTheBest.org (WNTB) to help hospitals and other providers improve their performance. In addition to presenting publicly available data on quality measures, the site offers ""best practices"" and tools, including case studies of high-performing hospitals. This project will expand WNTB's collection of case studies, produce reports that synthesize their findings, and create other content that highlights key strategies of high-performing health care organizations. These new products will add to the wealth of information already available on WNTB, providing hospitals with additional resources to improve the quality and safety of patient care.
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Health Research and Educational Trust
$289,694
Identifying Best Practices to Improve the Performance of Multi-Hospital Systems
More than half of U.S. hospitals belong to a multi-hospital system, accounting for the majority of all patient admissions. Recent data derived from the Hospital Quality Alliance measures that are publicly reported by Medicare show significant variability among these systems with respect to patient satisfaction, quality of care, and risk-adjusted mortality. But what is behind this variation? In this project, the research team will identify system characteristics and strategies that are related to better hospital system performance. The benchmark data produced for roughly 125 systems will be made available on the Fund's new Web site, WhyNotTheBest.org, as a resource for health care leaders seeking change within their organization.
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Institute for Healthcare Improvement
$1,050,000
Reducing Rehospitalizations, Phase 2
In phase 1 of this planned five-year demonstration to reduce preventable rehospitalizations, the project team identified effective strategies for reducing avoidable rehospitalizations and developed resource toolkits for the three states selected to participateâ€"Massachusetts, Michigan, and Washington. In phase 2, each state team will designate a leader to engage 10 to 20 hospitals in ""learning communities"" focused on improving care transitions and reducing avoidable rehospitalizations. Four policy committees of state and national leaders will address system-related barriers to reducing rehospitalizationsâ€"seeking to improve coordination across settings of care and develop statewide measurement strategies or public reporting policies. Other workgroups will be charged with developing recommendations for regulatory and payment reforms.
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Johns Hopkins University
$298,284
Improving Coordination of Care Through Electronic Health Record-Based Performance Measurement
Proper coordination of patient care is a hallmark of a high performance health system. However, the ability of health care organizations to measure the quality of coordination activitiesâ€"and, similarly, their impetus for improvementâ€"has been hampered by a lack of consensus on metrics and data collection strategies, and by a lack of tools to implement these measures. In this project, researchers at Johns Hopkins University, the National Committee for Quality Assurance, and the Park Nicollet Institute will team up to: 1) develop a comprehensive framework for measuring ambulatory care coordination that includes new data available through electronic health records (EHRs); 2) develop technical specifications for a series of care coordination measures that are applicable to practices with varying levels of EHR support; and 3) test the usability of the measures with 10 to 20 practice settings featuring varying levels of EHR support.
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Medical College of Wisconsin
$295,889
Evaluating the Impact of Public Reporting on Quality of Care in Wisconsin
The United States is moving toward greater transparency and value in health care, yet little is known about the impact public reporting has had on quality. The Wisconsin Collaborative for Healthcare Quality is a leader in this areaâ€"publicly reporting comparative measures of health care quality, sharing and refining best practices, and encouraging organizations in the state to agree on benchmark measures. The collaborative, which has reported performance data for five years, provides a unique opportunity to assess how public reporting affects health outcomes and quality of care. As part of this evaluation, the project team will assess changes in ambulatory care measures in Wisconsin, as well as changes in health care utilization and costs. The team will also survey health care providers to gather information on clinical interventions targeting specific medical conditions.
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Partners HealthCare System, Inc.
$220,126
Exploring the Value of National Electronic Prescribing Systems
Electronic prescribing systems enable the exchange of medication information among clinicians, pharmacies, patients, payers, and suppliers. Federal legislation will provide financial incentives for adopting electronic prescribing systemsâ€"and impose penalties for not adopting them. This project will assess current e-prescribing systems and their value. The investigators will review evidence of the effect e-prescribing has on costs, medication errors, care coordination, and medication adherence, and develop cost-benefit models to quantify the impact on costs and quality of care over time. By determining to whom the costs and benefits of e-prescribing value would accrue if the technology were adopted nationwide, this work will inform federal payment policy.
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Small Grants—Health Care Quality Improvement and Efficiency

Friends of the National Library of Medicine
$10,000
Personal Electronic Health Records to Transform Health Care: A National Conference
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Dean and Professor
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Norfolk, VA 23529
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Health Research and Educational Trust
$43,468
Spreading and Scaling up Strategies to Reduce Rehospitalizations
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Healthcare Information and Management Systems Society Foundation
$15,000
Capitol Hill "Steering Committee on Telehealth and Healthcare Informatics" Series, 2009/10
Neal Neuberger
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Johns Hopkins University
$49,772
Exploring the Appropriate Ethical Policies for Oversight of Quality Improvement Activities
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Harvey M. Meyerhoff Professor of Bioethics & Medicine
Johns Hopkins Berman Institute of Bioethics
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Baltimore, MD 21205
(410) 955-3119
jsugarm1@jhmi.edu

Mount Sinai School of Medicine of New York University
$48,686
A Systematic Review of Overuse of Health Care Services in the U.S.
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National Committee for Quality Assurance
$49,913
What Defines an Effective Regional Extension Center?
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Senior Executive, Strategic Initiatives
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Washington, DC 2005
(202) 955-5180
torda@ncqa.org

Palo Alto Medical Foundation Research Institute
$28,594
Estimating the Cost Associated with Hospital Readmissions Related to Hospital-Acquired Infections
Peter McNair

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Pennsylvania State University
$50,000
Evaluating the Impact of the IHI/CMWF Demonstration to Reduce Rehospitalizations
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Rand Corporation
$49,791
The Relationship Between Quality and Costs Among Individual Physicians
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Research Foundation of the City University of New York
$50,000
Evaluating the Relationships Between Team Coordination and Quality of Care and Patient Outcomes
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Rochester Individual Practice Association
$17,600
Engaging Physicians in Improving the Value of Care: Current Barriers and Recommendations to Solve Them
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(585) 242-9445
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Vermont State Legislature
$46,550
Financial Modeling for Vermont's Accountable Care Organization Pilot
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Patient-Centered Primary Care Initiative

Brigham and Women's Hospital Inc
$223,439
Evaluating a Medical Home Plan Coupled with Innovative Payment Reform for Primary Care, Phase 1
This evaluation will assess a unique medical home payment model under which primary care practices are paid a comprehensive, risk-adjusted, per-patient annual fee covering infrastructure and salaries. Currently, this global fee model is being tested as part of a medical home demonstration in nine primary care practices in Albany, N.Y., and Massachusetts. The proposed evaluation will determine if the new payment method is associated with reduced health system costs, improved patient care outcomes, and higher patient and physician satisfaction.
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Regents of the University of California
$408,545
Assessing a New System of Primary Care in Greater New Orleans
Several years after Hurricane Katrina, a large proportion of New Orleans residents are in poor health, lack health insurance, and have no regular source of care. To stabilize and strengthen primary care in the metropolitan area, the federal government awarded the Louisiana Department of Health and Hospitals a $100 million grant to assist in the restoration and expansion of outpatient neighborhood primary care services. The goals are to increase access to care, provide evidence-based care, help neighborhood physician practices become sustainable business entities, and develop an organized system of care that can serve the city in the future. This project will evaluate progress made in creating a network of primary care medical homes at the neighborhood level, assess improvements in access to primary care, and estimate health system costs. Project results will inform other efforts around the nation to improve primary care for underserved populations.
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Center for Health Policy Development
$362,679
State Consortium to Advance Medical Homes for Medicaid and Children's Health Insurance Program Beneficiaries
Based on a survey of state officials, the National Academy for State Health Policy (NASHP) identified 31 states with active initiatives to promote the patient-centered medical home as a way to deliver high-quality care for beneficiaries of Medicaid and the Children's Health Insurance Program. Most state officials are now seeking guidance on implementing the concept effectively and efficiently. In this project, NASHP will help eight states in their efforts to define the components of a medical home, develop criteria for recognizing clinics or physician practices as medical homes, revise primary care reimbursement policy, support physician office redesign, and monitor success. This work will be closely coordinated with the Qualis Health project to transform safety-net clinics into medical homes to ensure that promising policy approaches are shared with states participating in that initiative.
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University of Chicago
$489,638
Evaluation of The Commonwealth Fund's Medical Home Safety-Net Initiative, Phase I
In April 2008, the Fund's Board approved a five-year initiative to transform 50 safety-net clinics into patient-centered medical homes, which several studies indicate can improve quality, reduce costs, and narrow disparities in patient care. To assess the effectiveness of this ambitious initiative, a team based at the University of Chicago will evaluate whether the participating clinics in fact become medical homes, how medical homes affect quality and efficiency, and what factors are associated with a clinic's successful implementation of this care model. The project team will draw from organizational and patient survey data, interviews with clinic staff, a review of clinical data, and patient claims data (to determine the initiative's financial impact).
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President and Fellows of Harvard College
$466,890
Evaluating a Medical Home Demonstration in Colorado and Ohio
This project will evaluate a unique demonstration of a patient-centered medical home model being launched in Colorado and Ohio by five of the nation's leading insurers. A key component of the demonstration is a new payment system featuring a monthly, per-member care management fee and performance-based bonuses. Because the study will be led by the same Fund-supported research team currently assessing a multipayer demonstration in Rhode Island, data from three very different states will be available to see how contextual factors affect medical home adoption. Project staff will examine the implementation of the model and its impact on clinical quality, process outcomes, health care spending, patients' experiences, and satisfaction of practice staff.
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Joan and Sanford I. Weill Medical College of Cornell University
$300,000
Evaluating the Impact of Primary Care Practice Redesign on Quality, Cost, and Patient Experience
Health Services Improvement Fund Grant
While multiple medical home demonstrations are under way, one project in the Mid-Hudson Valley region of New York is particularly noteworthy. First, as the largest medical home demonstration in the country, it should produce robust quality and cost estimates that are generalizable to other small and mid-sized physician practices. Second, the Hudson Valley medical home effort builds on existing, multimillion-dollar regional initiatives to promote the adoption of electronic health records (EHRs) and implement a pay-for-performance program. For this evaluation, project staff will be able to assess the incremental effect of the medical home above and beyond EHRs and pay-for-performance. The results will show the impact of medical home redesign on clinical quality, health care costs, and patient experience.
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North Carolina Foundation for Advanced Health Programs, Inc.
$286,866
Diffusing the Community Care of North Carolina Model to Bring Medical Homes to Medicaid Beneficiaries
Community Care of North Carolina (CCNC) is a state-created program that connects Medicaid beneficiaries with a medical home. Consisting of 14 local health care networks and 3,200 primary care providers, CCNC has been shown to improve clinical care quality and produce considerable cost savings. Officials from 32 states and several national organizations have now requested guidance from North Carolina in replicating the program's success. This grant will enable the CCNC team to create practical, online resources to assist state officials, health plan representatives, provider organizations, and physicians outside of North Carolina to adopt or adapt the model. In addition, it will enable the provision of follow-up technical assistance to senior state officials.
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Qualis Health
$1,498,679
Transforming Safety-Net Clinics into Patient-Centered Medical Homes, Year 2
In April 2008, The Commonwealth Fund launched a five-year initiative to help safety-net primary care clinics become patient-centered medical homes and achieve benchmark levels of quality, efficiency, and patient experience. Due to the high caliber of the applications and enthusiastic cooperation of several local foundations, the initiative will expand from 50 clinics in four states to 68 clinics in five states: Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania. Over the next year, project staff will provide the states with technical assistance for improving the management, reorganization, and delivery of primary care. Early challenges and lessons learned will be disseminated nationally through a listserv, webinars, online resources, and Fund publications.
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Small Grants—Patient-Centered Primary Care Initiative

American Board of Internal Medicine
$24,846
Impact of Practice Infrastructure Supports on Patient Experience of Care
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Regents of the University of California
$14,128
Role of Medical Homes in Accountable Care Organizations
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President and Fellows of Harvard College
$31,702
Patient-Centered Medical Home Evaluators Collaborative
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Pacific Business Group on Health
$17,600
Impact of Pay-for-Performance Incentives on Patient Experience
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University of Rochester
$6,600
Defining and Achieving Patient-Centered Care: The Role of Clinicians, Patients, and Health Care Systems
Ronald M. Epstein, M.D.
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Rochester Center to Improve Communication in Health Care
Family Medicine Research Programs
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University of Texas Health Science Center
$9,603
Supplement to the Annals of Family Medicine to Publish Evaluation Results of the TransforMED Patient-Centered Medical Home National Demonstration Project
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Professor and Chairman
Department of Family and Community Medicine
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Urban Institute
$35,622
What Does a Medical Home Cost? Additional Analysis and Papers
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State Innovations

AcademyHealth
$474,670
The State Quality Institute: Advancing Health Care Quality Improvement Through Technical Assistance, Phase 2
In 2008, AcademyHealth and The Commonwealth Fund launched the State Quality Institute to assist nine state teams (from Colorado, Kansas, Massachusetts, Minnesota, New Mexico, Ohio, Oregon, Vermont, and Washington) in developing and implementing sustainable quality-improvement action plans centered on value-based purchasing, public reporting of performance, care coordination, or chronic care management. During phase 2, the institute will continue providing technical assistance to these states as they pursue their objectives. Each team will be able to consult in person with experts in the quality domains being targeted and will receive additional assistance through site visits, Web-based conferences, and other means. State teams will share their experiences with one another and report their progress, and AcademyHealth will disseminate results to state and national health policymakers through a Web site, newsletter articles, and two reports.
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Health Management Associates, Inc.
$96,080
States in Action Newsletter: Six Issues for 2009-10
States have developed a broad range of innovative strategies to promote health system performance. Some involve privateâ€“public collaborations to improve quality, and some reward health care providers for delivering better care at lower costs. Still others have sought to increase access to affordable health coverage and services. With a circulation of 15,000, the Commonwealth Fund e-newsletter, States in Action: A Bimonthly Look at Innovations in Health Policy, tracks promising initiatives like these and reports on them to local, state, and federal policymakers, researchers, program administrators, and grantmakers across the nation. This grant will support an additional six issues of States in Action for 2009-10. By providing progress reports on innovations described in earlier issues and highlighting new efforts as they become known, the newsletter will be a valuable resource as national health reform heats up in the coming year.
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Trustees of Tufts College
$91,276
The Massachusetts Health Insurance Connector: A Model for State and Federal Health Reform?
The Massachusetts Health Insurance Connector, an integral part of the state's comprehensive health insurance reform, was established to facilitate the purchase of quality, affordable health insurance by small businesses and individuals who lack access to employer-sponsored health coverage. For this project, researchers will analyze state data and interview government officials and representatives of small businesses, consumer groups, health plans, and other stakeholders to examine the structure of the Connector and its impact on the efficiency of the Massachusetts health care system, the affordability of insurance and scope of benefits, and administrative burdens. The findings will help determine how the Connector contributes to Massachusetts' health reform and possible lessons for other states and the nation.
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Urban Institute
$153,485
Monitoring the Impact of Health Care Reform in Massachusetts, Phase 3
The health care reform plan implemented in Massachusetts two years ago has yielded some impressive results. The survey conducted in the previous phase of this Fund-supported evaluation found that the state's uninsured rate was cut nearly in half at the end of the plan's first year, and residents saw a signficant drop in their out-of-pocket expensesâ€”all without any evidence of private coverage ""crowd-out."" In phase 3, the evaluation team will assess the reform's first- and second-year impact on insurance status, access to and use of health services, and out-of-pocket spending, particularly for uninsured and low- and moderate-income households. New survey questions will examine the early impact of the individual mandate, as well as new coverage programs and insurance-purchasing mechanisms created by the law.
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Small Grants—State Innovations

AcademyHealth
$25,000
State Health Research and Policy Interest Group Meetings
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Bailit Health Purchasing, LLC
$23,440
Insurance Standards and Policy Levers in Building a High Performance Health System
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Center for Health Policy Development
$48,425
Creating State and Federal Dialogue to Advance Quality Improvement: Patient Safety and Non-Payment for Preventable Conditions
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Greater New York Hospital Association
$1,200
Symposium on Health Care Services in New York: Research and Practice, 2009
Tim Johnson
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Greater New York Hospital Association
$1,000
Symposium on Health Care Services in New York: Research and Practice, 2008
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Jewish Healthcare Foundation of Pittsburgh
$49,302
Analyzing State Policies to Improve Health Care Cost and Improve Value
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San Francisco Department of Public Health
$50,000
Healthy San Francisco Program Evaluation

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Stanford University
$50,000
Application of Dissemination and Implementation Science to the Spread of Evidence-Based Practice: A Conference Proposal
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Special Populations

Health Care Disparities

The George Washington University
$192,343
Identifying Payment and Financing Options to Promote High Performance Community Health Centers
Federally qualified community health centers (CHCs) are an essential component of the health care safety net, providing millions of low-income Americans with many medical home services associated with high-quality primary care. Despite their importance as providers of care to the poor and uninsured, CHCs are funded through a piecemeal approach, raising questions as to whether payment and financing policies limit their ability to become high-performing medical homes. This project will: 1) identify state payment policies that provide health centers with incentives to serve as medical homes for their patients, as well as those policies that hinder high performance; and 2) develop options for modifying payment policy so that health center financing is aligned with the goal of high performance. This work will be informed by a survey of state associations representing health centers, interviews with leaders from CHC-affiliated health plans, and interviews with states that have innovative payment policies.
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$276,979
Learning from High-Performing Safety-Net Hospitals: Identifying Governance and Management Practices That Make a Difference
Health care leaders and the public agree that covering the uninsured should be a top national priority. But until the time universal coverage is achieved, the burden of caring for the nation's most vulnerable underserved and uninsured populations will fall disproportionately on public and other safety-net hospitals. Results from several studies over the past decade have indicated that safety-net hospitals face increasing challenges to providing adequate health care for these populations. This study's goal is to identify governance practices and organizational characteristics (such as ownership or affiliation with a Medicaid managed care plan or primary care clinics) of top safety-net hospitals that lower-performing hospitals could adopt in order to raise their financial performance and quality of care. To do this, project staff will analyze audited financial statements and standardized quality measures, conduct site visits and interviews, and prepare six case studies.
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Small Grants—Health Care Disparities

American Academy of Pediatrics, Inc.
$20,000
Starting Early: A Life Course Perspective on Child Health Disparities
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Fellowship in Minority Health Care

President and Fellows of Harvard College
$900,000
The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy: Support for Program Direction and Fellowships, 2009-10
Addressing pervasive racial and ethnic disparities in health and health care requires trained, dedicated physicians who can lead efforts to improve minority Americans' access to quality medical services. The Fellowship in Minority Health Policy has played an important role in addressing these needs. During the year-long program, physicians undertake intensive study in health policy, public health, and management, all with an emphasis on minority health issues, at Harvard University. Fellows also participate in special program activities. Since 1996, 61 fellows have successfully completed the program and received a master's degree in public health or public administration. In the coming year, program staff will select a 14th group of at least four fellows, provide current fellows with an enriched course of study and career development, and conduct evaluation activities.
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Child Development and Preventive Care

Boston Medical Center Corporation
$121,737
Recommending Content of Well-Child Care: Testing a New Approach to Evaluating Evidence, Phase 3
The Fund has led a funding partnership to build support among child health researchers for a new process of determining whether adequate evidence exists to make recommendations for the content of preventive care. The current ""gold standard"" requires evidence from randomized controlled trials; however, this does not make use of the wide variety of available evidence, leaving practitioners without authoritative guidance for much of what they do during well-child care visits. Researchers have made significant progress in reaching agreement on the need to create and apply new standards and on the key concepts underlying them. This project will extend that work by testing a new decision-making process to analyze results from two successful, developmentally focused intervention programs and develop recommendations for practice based on them.
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Center for Health Policy Development
$367,481
ABCD III: Improving Care Coordination, Case Management, and Linkages to Support Healthy Child Development, Year 1
The Fund's previous Assuring Better Child Health and Development (ABCD) initiativesâ€”in which state Medicaid agencies successfully partnered with others to increase the early identification of children with developmental problemsâ€”have uncovered substantial barriers in getting children not only appropriate health services but related educational, psychological, and social services as well. Led by the National Academy for State Health Policy (NASHP), this project will invite five states to change their policies, develop programs, and work with physician practices to create the systemic changes needed for effective coordination and referral networks.
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Authorization to Support the ABCD III Initiative for Up to Five States
The Fund's previous Assuring Better Child Health and Development (ABCD) initiativesâ€”in which state Medicaid agencies successfully partnered with others to increase the early identification of children with developmental problemsâ€”have uncovered substantial barriers in getting children not only appropriate health services but related educational, psychological, and social services as well. Led by the National Academy for State Health Policy (NASHP), this project will invite five states to change their policies, develop programs, and work with physician practices to create the systemic changes needed for effective coordination and referral networks.

Arkansas Department of Human Services
$59,986
AR LINKS (Linkages Improve Networks and Knowledge of Services): Creating Efficient Systems Linkages to Support Healthy Child Development

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Illinois Department of Healthcare and Family Services$60,000
Illinois Healthy Beginnings II: Coordinating Medical Homes and Community Services
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Minnesota Department of Human Services
$59,821
Minnesota's Communities Coordinating for Healthy Development
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Oklahoma Health Care Authority
$60,000
Connecting the Docs: Improving Care Coordination and Delivery of Developmental Screening and Referral Services in Oklahoma
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Oregon Department of Human Services
$60,000
ABCD for Oregon's Healthy Kids
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Children's Hospital of Philadelphia
$247,016
Tailoring Pediatric Preventive Care to Individual Needs, Phase 2: Validating a New Instrument
To ensure optimal care, preventive and developmental health care services should be tailored to the specific needs of a child and his or her family. In order to do so, health care providers must have information about the particular risks to health and development that the child faces, as well as the ability of the family to adequately address those risks. An earlier Fund project developed a brief, research-based questionnaire that would allow the physician to obtain this information and prescribe targeted preventive services. The proposed project will test the validity of that instrument, its effectiveness in identifying children at varying levels of risk, and the feasibility of using it in the practice setting. In addition, the research team will develop clinician guidance on the core preventive care services that ought to be provided to children at each age and risk level.
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The George Washington University
$76,328
Medicaid Case Management Policy Reform to Promote Healthy Child Development
Medicaid, which serves a disproportionate share of high-risk and disabled children, has long covered supportive services not typically covered by private insurance. Of these, care coordination is especially valuable, helping families of children with developmental delays or chronic health

problems access services and enhancing communication among their multiple providers. In an effort to reduce the billions of dollars Medicaid spends on case management–as targeted care coordination is known–recent federal policies have severely limited both eligibility for care coordination and the scope of services that qualify for reimbursement. States are unclear how to interpret and apply these policies, however. In the absence of clear federal guidance, states are preemptively scaling back services for fear of incurring financial penalties. This project will review and analyze existing laws and regulations and make recommendations for their interpretation and improving the efficient and judicious use of publicly funded care coordination services.

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The George Washington University

$140,000

A Policy Leadership Forum in Early Childhood Health and Development, Phase 2

Federal policy can be a powerful tool for improving children's access to health care and the quality of services they receive. With Fund support, a series of leadership forums was launched earlier this year to engage key congressional staff in policy issues related to child development and health. These meetings, which are to be held six to eight times a year, are intended to enhance participants' knowledge and foster bipartisan dialogue, all with the expectation that members of Congress will be better prepared to take informed action on legislation related to child development and health care. This proposal seeks to continue the forum and expand the number of participants.

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Health Management Associates, Inc.

$107,610

Case Studies of Systems of Child Health Care Coordination for States

Many child health care providers find coordinating care to be an extremely time-consuming and complicated service for which they receive no reimbursement. Especially difficult is coordinating developmental services delivered by providers who work outside the health care system, such as early childhood educators. Some states and communities are addressing these problems by creating systems of care coordination that are designed to support both families and practitioners. While these innovative efforts are early in their development, they offer potentially successful approaches that others might adopt. This project will study and report on some of the most promising models in order to foster their spread and encourage further innovation.

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National Committee for Quality Assurance

$294,690

Developing New Measures of the Quality of Well-Child Care, Phase 2

The ability to measure the quality of well-child care is essential to the successful implementation of quality improvement initiatives for children. Continuing the work begun in this project's first phase, researchers at the National Committee for Quality Assurance will refine the comprehensive set of pediatric preventive care measures they developed and test the measures with health plans and physician practices. In addition, the team will produce a report outlining data collection strategies and scoring methods, which will guide performance evaluation of plans and individual providers.

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Tufts Medical Center, Inc.

$208,096

Validating a Public-Domain Developmental Screening and Surveillance Instrument for Young Children, Phase 2

There is much variability in the quality of developmental monitoring at well-child care visits, partly because an efficient, standardized process has not been developed. In the first phase of this project, a research team created a template for the new Survey of Well-being for Young Children, a structured instrument that pediatricians can use to identify and monitor emerging developmental and behavioral problems, as well as family risk factors for poor outcomes in children. In the next phase, the team will complete the refinement, initial testing, and validation of the new instrument, which will be available in the public domain.

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University of Utah
$66,971
Observing the Content of Care During Well-Child Visits
Surveys of parents and pediatricians have shown that the content of care provided during well-child visits varies considerably from physician to physician and patient to patient. However, the extent of that variability, and whether it is appropriately based on each family's needs, remains in question. This project will enlist trained medical students in an effort to observe and document the content and processes of well-child care while it is being delivered by practitioners in their offices. Information based on these observations will be compared with recently published, age-specific benchmarks of good-quality care as defined by the American Academy of Pediatrics. The results of this study will be used to inform practitioners and policymakers about the current status of preventive pediatric care and the opportunities available to improve that care.
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University of Vermont
$252,143
Sustaining and Spreading Child Health Quality Improvement Partnerships to Promote Child Development Screening and Surveillance, Phase 3
With Commonwealth Fund support, the Vermont Child Health Improvement Program (VCHIP)â€"a self-sustaining organization that builds on a broad-based partnership that takes a measurement-based, systems approach to improving pediatric careâ€"has been successfully replicated in 10 states. In the third phase of work, the project team will spread the VCHIP model to another 10 states while continuing to provide support to existing improvement partnership sites. In addition, the team will build a national resource center, including a new Web site, to provide a foundation for future collaboration among the sites and expanded policy work at the federal and state levels.
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Small Grants—Child Development and Preventive Care

Association of Maternal and Child Health Programs
$14,580
Transforming our Public Health and Health Care Systems to Better Serve America's Women, Children, and Families: Plenary Session and Policy Report
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Center for Health Care Strategies, Inc.
$30,309
A Multi-State Analysis of Medicaid-Financed Services for Children with Complex Needs
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Children's Hospital Medical Center
$26,958
State Options to Implement the Children's Health Insurance Reauthorization Act of 2009
Lisa Simpson, M.B.

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DMA Health Strategies
$35,500
Case Study of State Strategies for Implementing Universal Early Childhood Developmental Screening
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DMA Health Strategies
$18,210
"Just in Time" Help for Primary Care Providers Managing Children's Emotional Problems: A Case Study of a Statewide Approach
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Harris Interactive, Inc.
$43,600
International Health Policy 2009: Expanded Sample and Survey of U.S. Pediatricians
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Medical University of South Carolina
$33,970
Infant Well-Child Care: Association with Readiness for First-Grade Learning by Low-Income Children
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National Initiative for Children's Healthcare Quality
$15,000
8th Annual Forum on Improving Children's Health Care
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Picker/Commonwealth Program on Quality of Care for Frail Elders

AcademyHealth
$170,906
The Commonwealth Fund/AcademyHealth Long-Term Care Colloquium, Year 6
Picker Program Grant
Launched in 2003, AcademyHealth's Long-Term Care Colloquium series provides a unique forum for exploring the most important issues facing long-term care consumers, providers, policymakers, and researchers. For the sixth colloquium, possible topics include: the development and impact of home- and community-based services, pay-for-performance demonstrations, end-of-life care, and international models of long-term care delivery. In the coming year, colloquia staff will reach out to consumer groups, such as the National Family Caregivers Alliance, to help the public become better informed about the implications of current long-term care policy and future directions.
Deborah L. Rogal

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American Association of Homes and Services for the Aging
$474,107
Advancing Excellence in America's Nursing Homes: Using Coalitions to Accelerate Progress, Phase 2
Picker Program Grant
Advancing Excellence in America's Nursing Homes, a coordinated nationwide effort to improve nursing home quality, is beginning to show results. Led at the national level by a broad-based coalition of stakeholder organizations, the effort is supported by 49 local area networks that recruit providers, consumers, and frontline workers and lend technical assistance to nursing homes. Last year, a Fund grant supported a national field network coordinator, development of Web-based educational materials and webinars, and small stipends to ensure consumer participation at events.
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Florida Atlantic University
$250,789
Reducing Avoidable Hospitalizations of Nursing Home Residents: Refinement and Evaluation of a Toolkit for Nursing Home Health Professionals
Picker Program Grant
Avoidable hospitalizations not only place the health and well-being of nursing home residents at risk, but they greatly increase health care expenditures. To help nursing homes reduce hospital admissions, this project will 1) refine a set of tools that have been developed to help long-term care providers manage selected acute medical conditions, and then 2) test the effectiveness of the intervention with a sample of nursing homes. The study will examine the homes' use of the tools, track their hospitalization rates, and estimate the cost of the intervention. The cost findings in particular will inform the development of new payment policies that remove current incentives for transferring residents to hospitals and help nursing homes acquire the capacity needed to safely treat sick residents on-site.
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Massachusetts Senior Care Foundation
$200,053
New Goals, New Partnerships: Next Steps for a National Effort to Advance Excellence in Nursing Homes
Picker Program Grant
Advancing Excellence in America's Nursing Homes, a coordinated, coalition-based nationwide effort to improve the quality of nursing home care, has demonstrated its effectiveness over the last two years. In addition to consolidating and updating the eight current goals, the campaign's national steering committee has recommended the pursuit of two new goals: promoting advance care planning and gauging job satisfaction among nursing home staff. In addition, the committee has recommended aligning goals with the Medicare-sponsored Quality Improvement Organizations' new work objectives, which include improving care transitions. This grant will enable Advancing Excellence to develop new metrics for measuring progress toward goals, test the practicability of new goals in three states prior to national rollout, and prepare for goal implementation. It will also support collaboration with the Institute for Healthcare Improvement's Fund-supported effort to reduce rehospitalizations.
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Pioneer Network
$334,923
The Pioneer Network Initiative: Moving into the Second Decade, Year 4
Picker Program Grant
Now in its second decade, the Pioneer Network in Culture Change is leading the effort to make resident-centered care the standard in U.S. nursing homes. Building on Fund-supported work begun last year, the Pioneer Network will continue to define core competencies for resident-centered practice of medicine in nursing homes, with an added focus on nursing; examine how state policies can promote culture change; and study the business case for culture change. Project staff will develop resident-centered care guidelines and case studies, create operational measures to assess culture change, and expand resources available on the Pioneer Web site.
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(585) 271-7570
bonnie.kantor@pioneernetwork.net

Small Grants—Picker/Commonwealth Program on Quality of Care for Frail Elders

AARP Foundation
$17,500
Feasibility of a State Long-Term Care Scorecard
Picker Program Grant
Susan Reinhard, Ph.D.
Senior Vice President, Public Policy
601 E Street, NW
Washington, DC 20049
(202) 434-3841
sreinhard@aarp.org

Brandeis University
$10,000
How Will We Meet the Health Service Needs of an Aging America? Princeton Conference, 2009
Picker Program Grant
Stuart H. Altman, Ph.D.
Professor & Chairperson, Council on Health Care Economics and Policy
The Florence Heller Graduate School
Institute for Health Policy - MS035
P.O. Box 549110
Waltham, MA 02454-9110
(781) 736-3803
altman@brandeis.edu

Brown University
$32,751
Disseminating the Long-Term Care Opinion Leader Survey: A Special Journal Supplement
Picker Program Grant
Edward Alan Miller, Ph.D.
Assistant Professor
A. Alfred Taubman Center for Public Policy and American Institutions
67 George Street, Box 1977
Providence, RI 02912
(401) 863-9311
edward_a_miller@brown.edu

George Mason University
$45,002
Spreading the Word: Documenting and Disseminating the Lessons and Successes of Advancing Excellence
Picker Program Grant
Robin E. Remsburg, Ph.D.
Associate Dean and Director
School of Nursing, College of Health & Human Services
4400 University Drive, MS 3C4, A361B Robinson Hall
Fairfax, VA 22030
(703) 993-1904
rremsbur@gmu.edu

Long Term Care Community Coalition
$38,000
Increasing Consumer Involvement in and Changing State CMP Funding Practices: Technical Assistance to Two States
Picker Program Grant
Richard Mollot
Executive Director
242 West 30th Street, Suite 306
New York, NY 10001
(212) 385-0355
richard@ltccc.org

Massachusetts Senior Care Foundation
$39,936

How Local Area Networks for Excellence (LANES) Can Strengthen the Ties Between Nursing Homes and Advancing Excellence: A Small Pilot
Picker Program Grant
Alice Bonner, Ph.D.
Executive Director
2310 Washington Street, Suite 300
Newton Lower Falls, MA 02462
(617) 558-0202
abonner@massseniorcare.org

New York University
$40,304
Nursing Homes as Clinical Training Sites: Recommendations to the Field
Picker Program Grant
Mathy Mezey, Ed.D.
Professor and Director
The Hartford Institute for Geriatric Nursing
College of Nursing
726 Broadway, 10th Floor
New York, NY 10003
(212) 998-5337
mm5@nyu.edu

International Health Care Policy and Practice

The Commonwealth Fund
$315,000
International Symposium on Health Care Policy, Fall 2009
The Fund's 12th annual International Symposium on Health Care Policy will focus on the nations' best practices for ensuring a health care workforce capable of supporting a high performance health system. In bringing together leading policymakers and researchers from Australia, Canada, France, Germany, the Netherlands, New Zealand, Switzerland, the United Kingdom, and the United States, the symposium will highlight other nations' strategies for addressing shortages of primary care physicians, the needs of an aging and increasingly diverse population, the shift to multidisciplinary team care, and changing expectations for health care professionals' accountability. Participants will explore ways to increase physician and nurse job satisfaction, payment mechanisms and incentives to encourage quality and efficiency, the evolution of health professionals' roles, and professional career competency. To reach the Washington, D.C., policy audience, the Fund and the Alliance for Health Reform will cosponsor a post-symposium briefing on Capitol Hill.
Robin Osborn
Vice President & Director, IHP
1 East 75th Street
New York, NY 10021
(212) 606-3809
ro@cmwf.org

The Commonwealth Fund
$1,680,500.00
Harkness Fellowships in Health Care Policy and Practice, 2010-11
Support for a 13th class of Harkness Fellows in Health Care Policy and Practice will allow the Fund to continue developing promising policy researchers and practitioners from Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom. In 2009, a Swiss Harkness Fellowship was launched in collaboration with the Careum Foundation, and funding from the Norwegian Research Council will enable expansion to Norway in 2010. Building on the partnership model that has enabled the European expansion of the Harkness Fellowships, sponsorship will be sought for a second Scandinavian Fellow and a French Harkness Fellowship in 2009. To leverage the potential of the Harkness Fellowship network for cross-national learning, the Fund will organize a policy forum in 2010 that brings together Harkness alumni and policymakers around reform issues relevant to the U.S.
Robin Osborn
Vice President & Director, IHP
1 East 75th Street
New York, NY 10021
(212) 606-3809
ro@cmwf.org

The Commonwealth Fund
$125,000
Harkness Fellowships Alumni Health Care Policy Forum, 2010
The Commonwealth Fund's Harkness Fellowships in Health Care Policy and Practice have, since 1998, produced a cadre of 129 alumni across Australia, Canada, Germany, the Netherlands, New Zealand, the U.K., and beginning in 2009, Switzerland. Recognizing the unique perspectives they offer, the Fund will support a high-level policy retreat to bring together a select group of Harkness alumni with leading health reform experts from each country. With the goal of engaging policymakers from the new U.S. administration, the forum will aim to identify lessons for the United States from abroad. Commissioned papers authored by Harkness alumni will be prepared for publication either by the Fund or in a special international issue of a policy journal.
Robin Osborn

Vice President & Director, IHP
1 East 75th Street
New York, NY 10021
(212) 606-3809
ro@cmwf.org

Harris Interactive, Inc.
$470,100
International Health Policy Survey, 2009
The 2009 International Health Policy Survey, the 12th in the annual series, will assess health care system performance from the perspective of primary care physicians. Conducted in nine countriesâ€"Australia, Canada, France, Germany, the Netherlands, New Zealand, the United Kingdom, the United States, and, for the first time, Switzerlandâ€"the survey will include questions about clinical information capacity, payment incentives, perception of health care quality, and factors viewed as impeding or supporting high-quality, efficient, patient-centered care. The findings, which will be released at the Fund's 2009 International Symposium and summarized in an article for Health Affairs, will likely generate substantial interest among health ministers, policymakers, researchers, and the media. The survey will also inform the Fund's work to advance the medical home model and the work of the Commission on a High Performance Health System.
Roz Pierson, Ph.D.
Vice President, Public Affairs and Policy
8320 Colesville Road #112
Silver Spring, MD 20910
(301) 502-9018
rpierson@harrisinteractive.com

Johns Hopkins University
$61,000
Cross-National Comparisons of Health Systems Quality Data, 2009
Comparing the U.S. health care system with the systems of other industrialized countries reveals striking differences in spending, availability and use of services, and health outcomes. This project will produce the 12th paper in a series of annual analyses of key health data for the 30 member nations of the Organization for Economic Cooperation and Development (OECD). The authors will update overall trends in health systems' performance, with an emphasis on measures of efficiency. The findings will be presented at the Fund's 2009 International Symposium on Health Care Policy and submitted to the journal Health Affairs. In addition, the Fund's online chartpack illustrating core OECD data will be updated as a resource for journalists, policymakers, and researchers.
Gerard F. Anderson, Ph.D.
Professor and Director
Center for Hospital Finance and Management
Bloomberg School of Public Health
624 North Broadway, Room 302 Hampton House
Baltimore, MD 21205
(410) 955-3241
ganderso@jhsph.edu

The Nuffield Trust
$75,000
Commonwealth Fund/Nuffield Trust International Conference on Health Care Quality Improvement, 2009
The annual symposia on health care quality improvement sponsored by The Commonwealth Fund and the United Kingdom's Nuffield Trust have provided a unique opportunity to build relationships among senior policymakers in the U.S. and the U.K., showcase innovations in quality improvement, and facilitate the exchange of ideas on what works and what does not. The theme of the 10th conference will be the use of incentives and provider payment policies to improve quality, promote integration of care, and control costs for chronically ill patients. Insights gained from the meeting will inform thinking on U.S. health care reform and the work of the Fund's Commission on a High Performance Health System.
Jennifer Dixon, Ph.D.
Director
59 New Cavendish Street
London W1G 7LP
United Kingdom
00 44 207 631 8450
jennifer.dixon@nuffieldtrust.org.uk

Urban Institute
$136,914
Enhancing the International Program's Communications and Publications Capacity
To strengthen the impact of the Fund's international program and spark creative health policy thinking in the United States, an external contractor will work with Fund staff to produce a series of issue briefs highlighting innovations in health policy and practice from abroad that might be transferable to the U.S. Given the high priority placed on health reform by the new Congress and Administration, these publications will provide a much-needed vehicle for bringing fresh ideas tried in other countries to the attention of U.S. policymakers, journalists, and researchers. The contractor will serve as the series' editor, helping to identify salient topics and working with international authors to present information in an accessible format.
Bradford H. Gray, Ph.D.
Senior Fellow
2100 M Street, NW

Washington, DC 20037
(202) 261-5342
bgray@urban.org

Small Grants—International Health Care Policy and Practice

AcademyHealth
$20,000
Netherlands Health Study Tours "Bounce-Back" Session
W. David Helms, Ph.D.
President and Chief Executive Officer
1150 17th Street, NW, Suite 600
Washington, DC 20036
(202) 292-6747
david.helms@academyhealth.org

Alliance for Health Reform
$34,200
Commonwealth Fund/Alliance International Roundtable on Comparative Effectiveness
Edward F. Howard
Executive Vice President
1444 Eye Street, NW, Suite 910
Washington, DC 20005-6573
(202) 789-2300
edhoward@allhealth.org

BundesgeschÃ¤ftsstelle QualitÃ¤tssicherung gGmbH
(National Institute for Quality Measurement in Health Care)
$50,720
Planning Grant for The Commonwealth Fund Initiative for Second Generation International Benchmarking in Health Care
Christof Veit, M.D.
Executive Director
KanzlerstraÃŸe 4
DÃ¼sseldorf 40472
Germany
+49 211 280729126
christof.veit@bqs-online.de

The Commonwealth Fund
$25,000
Innovations in Health Policy and Practice: An International Case Study Series
Robin Osborn
Vice President & Director, IHP
1 East 75th Street
New York, NY 10021
(212) 606-3809
ro@cmwf.org

The Commonwealth Fund
$7,500
Packer Policy Fellowships Roundtable on Health Care Policy and Practice
Robin Osborn
Vice President & Director, IHP
1 East 75th Street
New York, NY 10021
(212) 606-3809
ro@cmwf.org

The Commonwealth Fund
$41,750
Canada-U.S Forum on Innovations in Primary Care Policy and Delivery Systems
Robin Osborn
Vice President & Director, IHP
1 East 75th Street
New York, NY 10021
(212) 606-3809
ro@cmwf.org

Harris Interactive, Inc.

$14,000
Expansion of 2009 International Health Policy Survey to Include Italy
Roz Pierson, Ph.D.
Vice President, Public Affairs and Policy
8320 Colesville Road #112
Silver Spring, MD 20910
(301) 502-9018
rpierson@harrisinteractive.com

Health Services Research Association of Australia & New Zealand
$5,135
6th Biennial Health Services and Policy Research Conference
Jane Hall, Ph.D.
Professor
P.O. Box 123
Sydney, NSW 2007
Australia
+61 02 9514 4718
jane.hall@chere.uts.edu.au

Johns Hopkins University
$26,000
Gathering Additional Data Elements for International Comparisons
Gerard F. Anderson, Ph.D.
Professor and Director
Center for Hospital Finance and Management
Bloomberg School of Public Health
624 North Broadway, Room 302 Hampton House
Baltimore, MD 21205
(410) 955-3241
ganderso@jhsph.edu

Johns Hopkins University
$26,000
Disclosing Adverse Outcomes to Patients: An International Conference to Advance Policy and Practice
Albert W. Wu, M.D.
Professor, Health Policy and Management
Health Services Research and Development Center
Bloomberg School of Public Health
624 N. Broadway
Baltimore, MD 21205-1901
(410) 955-6567
awu@jhsph.edu

McGill University Health Centre Research Institute
$46,260
National Initiatives to Implement Electronic Health/Medical Records: A Case Study of the Canadian Experience in Contrast to the United States
Robyn Tamblyn, Ph.D.
Professor
Clinical & Health Informatics Research
1140 Pine Avenue West
Montreal, Quebec H3A 1A3
(514) 934-1934
robyn.tamblyn@mcgill.ca

Scientific Institute for Quality of Healthcare
$37,863
Expansion of 2009 International Health Policy Survey to Include the Netherlands
Richard Grol, Ph.D.
Head of the Center for Quality of Care Research
Raboud University Nijmegen Medical Centre
P.O. Box 9101 114
Nijmegen 6500 HB
The Netherlands
+31 24 361 5305
r.grol@kwazo.umcn.nl

Communications

Harris Interactive, Inc.
$55,000
Health Care Opinion Leaders Survey, Year 4
In 2007, the Fund re-launched its quarterly series of online surveys of health care opinion leaders as a collaboration with the weekly Modern Healthcare. The surveys, conducted by Harris Interactive, ask about a range of key health policy issues and options for addressing them. Results are published in the print and online editions of Modern Healthcare, as well as on the Fund's Web site, supplemented with a data brief and original commentaries by top policy experts. Building on the success of this project to date, the Fund will support an additional year of quarterly surveys covering issues closely aligned with the work of the Fund's Commission on a High Performance Health System.
Roz Pierson, Ph.D.
Vice President, Public Affairs and Policy
8320 Colesville Road #112
Silver Spring, MD 20910
(301) 502-9018
rpierson@harrisinteractive.com

IPRO, Inc.
$247,611
Constructing a Working Demonstration Model of a National Health Care Benchmarking Tool, Part 2
Through a previous Board grant, The Commonwealth Fund developed a Web resource, WhyNotTheBest.org, to enable health care professionals to compare their organization's performance against that of peer groups over time, to access case studies and improvement tools, and to interact with colleagues. The goal is to give providers the resources they need to measure and improve. The first phase of the site will be launched in December 2008 at the national meeting of the Institute for Healthcare Improvement. In 2009, the resource will be further developed, based on feedback from users, partner organizations, and Fund colleagues. Project staff will add new data sets (e.g., hospital readmission rates); additional functionality (e.g., a performance improvement calculator); and features for particular audiences (e.g., safety-net hospitals).
Jaz-Michael King
Senior Director, Communications
1979 Marcus Avenue
Lake Success, NY 11042-1002
(516) 326-7767
jmking@ipro.us

Pear Tree Communications, Inc.
$175,389
WhyNotTheBest.org: A Web Resource for Quality Improvement
Through a previous Board grant, The Commonwealth Fund developed a Web resource, WhyNotTheBest.org, to enable health care professionals to compare their organization's performance against that of peer groups over time, to access case studies and improvement tools, and to interact with colleagues. The goal is to give providers the resources they need to measure and improve. The first phase of the site will be launched in December 2008 at the national meeting of the Institute for Healthcare Improvement. In 2009, the resource will be further developed, based on feedback from users, partner organizations, and Fund colleagues. Project staff will add new data sets (e.g., hospital readmission rates); additional functionality (e.g., a performance improvement calculator); and features for particular audiences (e.g., safety-net hospitals).
Martha Hostetter
Partner
3035 Lincoln Boulevard
Cleveland Heights, OH 44118-2033
(216) 262-0717
mh@cmwf.org

Project HOPE/The People-to-People Health Foundation, Inc.
$454,000
Web Publishing Alliance with Health Affairs
The Fund's online publishing partnership with the policy journal Health Affairs has provided opportunities to publish Fund-supported research faster and more frequently than traditional means allow, while also raising the Fund's professional and public profile. This grant will provide Health Affairs with an additional two years of funding for Web operations as well as development of new media and social networking capabilities on the journal's Web site.
Susan Dentzer
Editor-in-Chief, Health Affairs
7500 Old Georgetown Road, Suite 600
Bethesda, MD 20814
(301) 656-7401
sdentzer@projecthope.org

Small Grants—Communications

Association of Health Care Journalists
$35,000
ACHJ Annual Conference, "Covering Aging in the 21st Century" Workshop, and Talking Health Webcast Series
Len Bruzzese
Executive Director

10 Neff Hall
Columbia, MO 65211
(573) 884-5606
len@healthjournalism.org

Trustees of Columbia University in the City of New York
$35,000
Educational Insert in Columbia Journalism Review, 2009
Louisa Kearney
Advertising Director
2950 Broadway
New York, NY 10027
(212) 883-2828
ldkpub@aol.com

National Business Coalition on Health
$49,847
Purchasing High Performance Newsletter
Andrew Webber
President and CEO
1015 18th Street, NW, Suite 730
Washington, DC 20036
(202) 775-9300
awebber@nbch.org

Project HOPE/The People-to-People Health Foundation, Inc.
$50,000
"Cost Containment" Thematic Issue of Health Affairs, 2009
Susan Dentzer
Editor-in-Chief, Health Affairs
7500 Old Georgetown Road, Suite 600
Bethesda, MD 20814
(301) 656-7401
sdentzer@projecthope.org

Society of American Business Editors and Writers, Inc.
$15,000
Society of American Business Editors and Writers' Annual Conference and Web-Based Trainings for Journalists, 2009
David Beal
Active Executive Director
University of Missouri-Columbia
385 McReynolds Hall
Columbia, MO 65211
(651) 216-7677
davebiz@q.com

WGBH Educational Foundation
$50,000.00
Frontline's "Sick Around America"
David Fanning
FRONTLINE Executive Producer
One Guest Street
Boston, MA 02135
(617) 300-5400
david_fanning@wgbh.org

Organizations Working with Foundations

AcademyHealth
$249,625
Partnering with AcademyHealth to Promote a High Performance Health System, 2009-10
W. David Helms, Ph.D.
President and Chief Executive Officer
1150 17th Street, NW, Suite 600
Washington, DC 20036
(202) 292-6747
david.helms@academyhealth.org

AcademyHealth

$301,423
Partnering with AcademyHealth to Promote a High Performance Health System, 2008-09
W. David Helms, Ph.D.
President and Chief Executive Officer
1150 17th Street, NW, Suite 600
Washington, DC 20036
(202) 292-6747
david.helms@academyhealth.org

AcademyHealth
$24,500
General Support
W. David Helms, Ph.D.
President and Chief Executive Officer
1150 17th Street, NW, Suite 600
Washington, DC 20036
(202) 292-6747
david.helms@academyhealth.org

The Center for Effective Philanthropy
$5,000
General Support
Phil Buchanan
Executive Director
675 Massachusetts Avenue, 7th Floor
Cambridge, MA 02139
(617) 492-0800
philb@effectivephilanthropy.org

Foundation Center
$15,000
General Support
Bradford K. Smith
President
79 Fifth Avenue
New York, NY 10003-3076
(212) 620-4230
bks@fdncenter.org

Grantmakers for Children, Youth, and Families, Inc.
$2,500
General Support
Stephanie McGencey, Ph.D.
Executive Director
8757 Georgia Avenue, Suite 540
Silver Springs, MD 20910
(301) 589-4293
smcgencey@gcyf.org

Grantmakers in Aging, Inc.
$6,500
General Support
Carol A. Farquhar
Executive Director
7333 Paragon Rd., Ste. 220
Dayton, OH 45459-4157
(937) 435-3156
cfarquhar@giaging.org

Grantmakers In Health
$15,000
General Support
Lauren J. LeRoy, Ph.D.
President and Chief Executive Officer
1100 Connecticut Avenue, NW, Suite 1200
Washington, DC 20036
(202) 452-8331
lleroy@gih.org

Health Services Research Association of Australia & New Zealand
$1,500
General Support
Jackie Cumming, Ph.D.
President
P.O. Box 123
Sydney, NSW 2007
Australia
+61 02 9514 4723
jackie.cumming@vuw.ac.nz

Independent Sector
$12,500
General Support
Diana Aviv
President and Chief Executive Officer
1602 L Street, NW, Suite 900
Washington, DC 20036
(202) 467-6100
diana@independentsector.org

International Society for Quality in Health Care, Inc.
$1,200
General Support
Roisin Boland
Chief Executive Officer
2 Parnell Square East
Dublin 1
Ireland
+353 1 871 7049
rboland@isqua.org

Nonprofit Coordinating Committee of New York
$35,000
General Support
Michael E. Clark
President
1350 Broadway, Suite 1801
New York, NY 10018-7802
(212) 502-4191
mclark@npccny.org

Philanthropy New York
$15,100
General Support
Ronna D. Brown
President
79 Fifth Avenue, Fourth Floor
New York, NY 10003-3076
(212) 714-0699
rbrown@philanthropynewyork.org

Rockefeller Archive Center
$90,000
Transfer and Maintenance of The Commonwealth Fund's Archives, Part 13
This grant will support the transfer, processing, and storage of additional Commonwealth Fund materials at the Rockefeller Archive Center, which has housed the Fund's archives since 1985.
Lee R. Hiltzik, Ph.D.
Assistant Director, Head of Donor Relations and Collection Development
15 Dayton Avenue
Sleepy Hollow, NY 10591-1598
(914) 366-6345
lhiltzik@rockarch.org

Other Continuing

National Hispanic Health Foundation
$5,000

Fifth Annual Hispanic Health Professional Student Scholarship Gala Dinner
Elena Rios, M.D.
President
1411 K Street, NW, Suite 200
Washington, DC 20005
(202) 628-5895
nhma@nhmamd.org

National Medical Fellowships
$1,000
National Medical Fellowships Los Angeles Awards Gala, 2009
Esther R. Dyer, D.L.S.
President and CEO
5 Hanover Square, 15th Floor
New York, NY 10004
(212) 483-8880
erdyer@nmfonline.org

New York Academy of Medicine
$6,000
New York Academy of Medicine Gala, 2009
Jo Ivey Boufford, M.D.
President
1216 Fifth Avenue
New York, NY 10029-5293
(212) 822-7201
jboufford@nyam.org

Primary Care Development Corporation
$6,000
Primary Care Development Corporation Spring Gala, 2009
Ronda Kotelchuck
Executive Director
22 Cortlandt Street, 12th Floor
New York, NY 10007
(212) 437-3917
rkotelchuck@pcdcny.org

United Hospital Fund of New York
$8,500
United Hospital Fund Gala, 2008
James R. Tallon, Jr.
President
Empire State Building
350 Fifth Avenue, 23rd Floor
New York, NY 10118
(212) 494-0700
jtallon@uhfnyc.org

jtallon@uhfnyc.org

2009 ANNUAL REPORT
SUMMATION OF PROGRAM AUTHORIZATIONS

Year ended June 30, 2009

	Major Program Grants	Small Grants Fund Grants	Total Authorizations
Program Grants Approved			
High Performance Health System	$13,897,912	$1,269,171	$15,167,083
Commission Activities	$1,603,371	$160,000	$1,763,371
Future of Health Insurance	$1,947,165	$206,972	$2,154,137
Medicare's Future	$1,753,678	$101,907	$1,855,585
Health Care Quality Improvement and Efficiency (See Notes 1 and 3)	$3,741,406	$412,824	$4,154,230
Patient-Centered Primary Care Initiative	$4,036,781	$140,101	$4,176,882
State Innovations	$815,511	$247,367	$1,062,878
Special Populations	$5,130,170	$461,620	$5,591,790
Health Care Disparities	$469,322	$10,000	$479,322
Commonwealth Fund / Harvard University Fellowships in Minority Health Policy	$900,000		$900,000
Child Development and Preventive Care	$2,182,072	$228,127	$2,410,199
Picker / Commonwealth Program on Quality of Care for Frail Elders (See Notes 2 & 3)	$1,578,776	$223,493	$1,802,269
International Health Care Policy and Practice	$2,863,514	$337,428	$3,200,942
Communications	$991,313	$160,000	$1,151,313
Other Continuing Programs	$774,848	$77,347	$852,195
Total Program Grants Approved	$23,657,757	$2,305,566	$25,963,323
Grants Matching Gifts by Directors and Staff			$508,013
Program Authorizations Cancelled or Refunded and Royalties Received			($736,071)
Total Program Authorizations			$25,735,265

NOTES:
(1) Frances Cooke Macgregor Award of $371,856 in 2008-09.
(2) Picker Program Grants totalled $1,802,069 in 2008-09.
(3) Health Services Improvement Award of $300,000 in 2008-09.

1 East 75th Street
New York, NY 10021
Tel: 212.606.3800

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Suite 600
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